II

110TH CONGRESS
1ST SESSION

S. 1783

To provide 10 steps to transform health care in America.

IN THE SENATE OF THE UNITED STATES

JULY 12, 2007

Mr. ENZI introduced the following bill; which was read twice and referred to the Committee on Finance

---

A BILL

To provide 10 steps to transform health care in America.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Ten Steps to Transform Health Care in America Act".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. PURPOSES.

It is the purpose of this Act to—

(1) eliminate unfair tax treatment of health insurance thereby expanding choices, coverage, and control over health care for all Americans;

(2) increase affordable options for working families to purchase health insurance through a standard tax deduction;

(3) ensure that affordable health insurance is available to low-income individuals through the provision of a refundable, advanceable, assignable tax-based subsidy;

(4) provide cross-State pooling to reduce health care costs and increase accessibility for small business owners, unions, associations, and their workers, members, and families;

(5) blend the individual and group health insurance markets to extend important Health Insurance Portability and Accountability Act portability protections to the individual market so that insurance security can better move with an individual from job to job;

(6) emphasize preventive health care and help individuals with chronic diseases better manage their health so America will finally have health care and not sick care;

(7) give individuals the choice to convert the value of Medicaid and SCHIP program benefits into private health insurance, putting Americans in control of their health care, not the Federal government;

(8) save lives and money by better coordinating health information technology to improve health care delivery;

(9) increase access to primary care in rural and frontier areas by helping future providers and nurses pay for their education, and giving seniors more op-

tions to receive care in their homes and communities; and

(10) decrease the sky-rocketing cost of health care by restoring reliability in our medical justice system through State-based solutions.

SEC. 3. DEFINITIONS.

Except as otherwise provided, in this Act:

(1) ADULT INDIVIDUAL.—The term "adult individual" means an individual who—

(A) is—

(i) age 19 or older;

(ii) a resident of a State;

(iii)(I) a United States citizen; or

(II) an alien with permanent residence; and

(iv) not a dependent child; and

(B) in the case of an incarcerated individual, such an individual who is incarcerated for less than 1 month.

(2) ALIEN WITH PERMANENT RESIDENCE.—The term "alien with permanent residence" has the meaning given the term "qualified alien" in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641).

(3) APPLICABLE STATE LAW.—The term "applicable State law" means the health insurance and related laws and regulations of a State.

(4) DEPENDENT CHILD.—The term "dependent child" has the meaning given the term "qualifying child" in section 152(c) of the Internal Revenue Code of 1986.

(5) HEALTH INSURANCE ISSUER.—The term "health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (6)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974).

(6) HEALTH MAINTENANCE ORGANIZATION.—The term "health maintenance organization" means—

(A) a federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act);

(B) an organization recognized under State law as a health maintenance organization; or

(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

(7) QUALIFIED CORE COMPATIBLE PLAN.—The term "qualified core compatible plan" means a compatible qualified core plan that meets the requirements of section 103.

(8) QUALIFIED CORE PLAN.—The term "qualified core plan" means a qualified core plan described under section 102.

(9) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services, unless expressly provided for otherwise in this Act.

(10) STATE.—The term "State" means each of the several States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, and other territories of the United States.

(11) STATE OF RESIDENCE.—The term "State of residence", with respect to an individual, means the State in which the individual has primary residence.

TITLE I—AFFORDABLE HEALTH INSURANCE COVERAGE

Subtitle A—Individual Coverage Responsibility and Availability of Core Plan Options

SEC. 101. COVERAGE RESPONSIBILITY.

(a) INDIVIDUAL RESPONSIBILITY.—

(1) ADULT INDIVIDUALS.—Not later than 3 years after the date of enactment of this Act, each adult individual shall be encouraged to enroll in a qualified health plan that meets at least the requirements applied under section 224(d)(2) of the Internal Revenue Code of 1986.

(2) DEPENDENT CHILDREN.—Each adult individual enrolled in a health plan described in paragraph (1) shall have the responsibility to enroll (or provide evidence of enrollment of) each dependent child of the adult individual in such a health plan, or in a Federal or State governmental health coverage program for which such dependent child is eligible and which does not otherwise qualify as a health plan for purposes of paragraph (1).

(3) DETERMINATIONS OF ENROLLMENT.—An individual may demonstrate compliance with this subsection through—

(A) proof of enrollment of such individual and dependent children of such individual (if any) provided on the individual Federal tax return of the individual pursuant to regulations developed by the Secretary of the Treasury; or

(B) proof of such enrollment obtained pursuant to automatic enrollment as provided for in subsection (d).

(b) ELIGIBILITY FOR HEALTH INSURANCE ASSISTANCE.—Subject to this subsection and subsection (c), an individual and such dependent children of such individual who is enrolled in a health plan described in subsection (a)(1) shall be eligible to elect to receive—

(1) a standard Federal income tax deduction for health insurance; or

(2) an income-based tax credit subsidy.

(c) ENCOURAGEMENT.—Each State shall determine appropriate mechanisms, which may not include revocation or ineligibility for coverage under a qualified core plan or qualified core compatible plan, to encourage each adult individual to demonstrate coverage under a health plan described in subsection (a)(1) for such individual and compliance by such individual with the terms of paragraph (2) with respect to any dependent children of such individual.

(d) AUTOMATIC ENROLLMENT.—

(1) IN GENERAL.—Each State shall implement mechanisms to automatically enroll an uninsured individual for health coverage if—

(A) such individual presents for treatment to a licensed health care facility or provider without health coverage under a health plan described in subsection (a)(1) or otherwise under a Federal or State government health coverage program; or

(B) such individual designates the lack of such coverage on the Federal tax return filed by such individual.

(2) TYPE OF PLAN.—The mechanisms implemented under paragraph (1) shall ensure that an individual is automatically enrolled, on a randomized basis, in a qualified core plan offered in the State of residence of the individual, or in any Federal or State government health program if the individual is eligible for such enrollment.

(3) COORDINATION.—The Secretary shall coordinate with the Secretary of the Treasury and the State insurance commissioners to develop procedures for providing notification to relevant entities regarding individuals who have indicated a lack of health coverage on Federal tax returns, or who have pre-

sented to a licensed healthcare entity or provider as provided for in paragraph (1)(A).

SEC. 102. QUALIFIED CORE PLANS.

(a) OFFERING OF COVERAGE.—Each health insurance issuer offering health insurance coverage in a State shall offer at least one certified qualified core plan to individuals residing in that State and shall market such plans in a manner that is substantially similar to the manner in which such issuer markets coverage or other health insurance plans such issuer offers in the State. If a State determines that a health insurance issuer is failing to offer (or market) such coverage in the State as provided for in this subsection, the State shall not license such issuer to offer health insurance coverage in such State (or revoke any existing license of such issuer effective upon the expiration of the subsequent plan year).

(b) CERTIFICATION.—Each State shall certify a plan as a qualified core plan if the plan meets the requirements of subsection (c).

(c) REQUIREMENTS.—

(1) IN GENERAL.—To be certified as a qualified core plan, the plan shall—

(A) provide coverage for benefits, items, or services as required by the State;

(B) provide coverage for basic preventive items or services, as the State may define such items or services, in accordance with paragraph (2);

(C) provide coverage for medical self-management and for items or services needed for such self-management, as the State may define such items or services;

(D) require payment of the applicable standard premium for coverage under the plan (as determined in accordance with subsection (d));

(E) adhere to the cost sharing limitations prescribed under subsection (e);

(F) provide for the submission of data as required under subsection (f); and

(G) comply with any other requirements applicable under State law.

(2) BASIC PREVENTIVE ITEMS OR SERVICES.—The basic preventive items or services for which coverage shall be provided under a qualified core plan shall be determined—

(A) pursuant to applicable State law; or

(B) if no such State law is in effect, based on standards and guidelines issued by the Sec-

retary (in consultation with the National Association of Insurance Commissioners).

(d) STANDARD PREMIUM AMOUNT.—

(1) IN GENERAL.—Except as provided for in this subsection, the standard premium for coverage under a qualified core plan for the initial plan year following the date on which the requirement under section 101(a) applies shall be—

(A) $2,500 for individual coverage; and

(B) $5,000 for family coverage.

(2) CPI ADJUSTMENT.—Each of the amounts provided for under paragraph (1) shall be annually increased, beginning in the second plan year following the date on which the requirement under section 101(a) applies, by the percentage increase in the Consumer Price Index for the previous plan year. As used in the preceding sentence, the term "Consumer Price Index" means the last Consumer Price Index for all-urban consumers published by the Department of Labor.

(e) COST SHARING LIMITATIONS.—

(1) IN GENERAL.—A qualified core plan shall comply with the following cost sharing limitations:

(A) DEDUCTIBLES.—The amount of any deductible shall not exceed $2,500 for a plan year.

(B) COPAYMENTS.—The amount of any copayments shall not exceed 20 percent.

(C) ANNUAL LIMITS.—The annual limit on cost sharing payment shall not exceed $5,000.

(2) ADJUSTMENT FOR INFLATION.—Each of the amounts provided for under paragraph (1) shall be annually increased, beginning in the second plan year following the date on which the requirement under section 101(a) applies, by the percentage increase in the Consumer Price Index for the previous plan year. As used in the preceding sentence, the term "Consumer Price Index" means the last Consumer Price Index for all-urban consumers published by the Department of Labor.

(3) NO APPLICATION OF COST SHARING FOR PREVENTION AND MEDICAL SELF-MANAGEMENT.—A qualified core plan may not impose cost sharing requirements on—

(A) basic preventive items or services; or

(B) medical self-management items or services.

(4) DECERTIFICATION.—A State shall suspend or revoke the certification of any qualified core plan if the State determines that any policy or procedure implemented with respect to the plan has the effect, or likely effect, of materially altering the overall level of cost sharing obligations that may be required of enrollees under the plan. Notwithstanding the previous sentence, an individual covered under such a plan may continue coverage under such plan through the expiration of the current plan year, or if such expiration date is less than 6 months from the date of decertification, for an additional plan year.

(f) ACTUARIAL VALUE DATA AND APPLICATION.—

(1) IN GENERAL.—A health insurance issuer shall annually submit to the State insurance commissioner and the Secretary a determination as to the aggregate actuarial value of each qualified core plan and qualified core compatible plan offered by the issuer in the State. In developing and submitting such data, the issuer shall utilize actuarial standards established by the National Association of Insurance Commissioners.

(2) PUBLICATION AND SUBMISSION TO SECRETARY.—A State insurance commissioner shall—

(A) compile all data received under paragraph (1) with respect to the State;

(B) publish such data in a manner that enables individuals in the State to use such data in making health insurance decisions; and

(C) submit such data in report form to the Secretary.

(3) USE OF DATA.—

(A) IN GENERAL.—The Secretary shall, using the data provided under paragraph (2)(C), annually publish a national standard qualified core plan actuarial value (referred to as the "National actuarial value").

(B) QUALIFIED CORE COMPATIBLE PLANS.—For provisions relating to the use of the National actuarial value with respect to qualified core compatible plans, see section 103(c)(1)(D).

(4) SUSPENSION OR REVOCATION OF CERTIFICATION.—The State shall suspend or revoke the certification of any qualified core plan or qualified core compatible plan, upon the expiration of the subsequent plan year, for which a health insurance issuer has failed to submit data as required under paragraph (1).

(g) APPLICATION TO STATE LAW.—Unless provided otherwise in this Act, nothing in this Act shall be construed to preempt State laws relating to health insurance, including State benefit mandate laws, consumer protection requirements, solvency and related fiscal requirements for qualified core plans.

(h) MARKET AVAILABILITY STUDY.—

(1) ASSESSMENT.—Prior to the implementation of regulations relating to the certification of qualified core plans under this Act, the Secretary, in consultation with the National Association of Insurance Commissioners, shall conduct an assessment of the effect of the application of the National actuarial value as a requirement for certification of qualified core compatible plans under section103(c)(1)(D), including the effect of such application on the affordability of qualified core compatible plans, the entry of health insurance issuers into the qualified core plan and qualified core compatible plan market, and on health insurance market access, affordability, and competition.

(2) REPORT.—The Secretary shall submit to Congress a report concerning the results of the assessment conducted under paragraph (1).

SEC. 103. QUALIFIED CORE COMPATIBLE PLANS.

(a) OFFERING OF COVERAGE.—A health insurance issuer offering health insurance coverage in a State may offer one or more certified qualified core compatible plans to individuals residing in that State.

(b) CERTIFICATION.—Each State shall certify a plan as a qualified core compatible plan if the plan meets the requirements of subsection (c).

(c) REQUIREMENTS.—

(1) IN GENERAL.—To be certified as a qualified core compatible plan, the plan shall—

(A) provide coverage for benefits, items, or services as required by the State;

(B) provide coverage for basic preventive items or services;

(C) provide coverage for medical self-management and for items or services needed for such self-management, as the State may define such items or services;

(D) have an actuarial value that is not less than the national standard actuarial value determined under section 102(f)(3)(A); and

(E) comply with any other requirements imposed by the State.

(2) BASIC PREVENTIVE ITEMS OR SERVICES.—The basic preventive items or services for which cov-

erage shall be provided under a qualified core compatible plan shall be determined is the same manner as provided for under section 102(c)(2).

(3) PREMIUMS AND COST SHARING.—Except as provided in this Act, premium and cost sharing requirements applicable to qualified core compatible plans shall be determined in accordance with applicable State law.

(d) APPLICATION OF STATE LAW.—Unless specifically provided otherwise in this Act, nothing in this Act shall be construed to preempt State laws relating to health insurance, including State benefit mandate laws, consumer protection requirements, and solvency and related fiscal requirements for qualified core compatible plans.

SEC. 104. CERTIFICATION.

(a) IN GENERAL.—A health insurance issuer shall submit an application to the State insurance commissioner for the certification of a health plan as a qualified core plan or a qualified core compatible plan for purposes of offering coverage under such plan in the State.

(b) REGULATIONS.—The Secretary, in consultation with the National Association of Insurance Commissioners, shall promulgate regulations that provide standards and procedures for the certification, and suspension or revocation of the certification, of qualified core plans

and qualified core compatible plans to ensure that such plans comply, and maintain such compliance, with the requirements and standards applicable to such plans under this title.

SEC. 105. STATE-BASED RISK ADJUSTMENTS.

(a) IN GENERAL.—The State shall seek to lessen such material risk selection as may occur among qualified core plans, qualified compatible core plans, and other licensed health insurance products (not including self-insured plans) through the application of State risk adjustment requirements that are certified by the Secretary as meeting standards established by the Secretary (in consultation with the National Association of Insurance Commissioners).

(b) ASSESSMENT AND REPORT.—

(1) IN GENERAL.—Prior to the development of standards under subsection (a), the Secretary, in consultation with the National Association of Insurance Commissioners, shall conduct an assessment of—

(A) the degree of the actual or actuarially anticipated material adverse selection among qualified core plans, qualified core compatible plans, and other insured health plans; and

(B) the comparative efficiency of State risk adjustment requirement options to minimize such hazards.

(2) REPORT.—The Secretary shall submit a report to Congress concerning the results of the assessment conducted under paragraph (1). Such report shall include such recommendations as the Secretary may include for additional or future legislation to adjust the standards developed under subsection (a) if the Secretary determines that such legislation is reasonably necessary to provide for the effective application of the requirements of subsection (a).

SEC. 106. RELATION TO SELF-INSURED PLANS.

(a) IN GENERAL.—An individual who is enrolled in health care coverage under a self-insured health plan (as defined for purposes of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.)) shall be deemed to be in compliance with the requirements of section 101(a), and other than as expressly provided for otherwise in this Act, current law with respect to such plans shall remain in effect.

(b) DEMONSTRATION OF ACTUARIAL VALUE.—The health insurance issuer of a plan described in subsection (a), shall submit to the Secretary of Labor evidence dem-

onstrating that the coverage alternative involved meets the requirements of such subsection.

(c) CERTIFICATION PROCESS.—Certification, or suspension or revocation of certification, of health plans under this section shall be administered by the Secretary of Labor in consultation with the State insurance commissioner.

SEC. 107. STATE FLEXIBILITY AND ENFORCEMENT.

(a) IN GENERAL.—

(1) STATE AUTHORITY.—Subject to subsection (d), each State shall require that health insurance issuers that issue, sell, renew, or offer health insurance coverage in the State meet the requirements established under this subtitle with respect to such issuers and with respect to qualified core plans and qualified core compatible plans.

(2) FAILURE TO IMPLEMENT REQUIREMENTS.—In the case of a State that fails to substantially implement and enforce the requirements set forth in this subtitle with respect to health insurance issuers in the State, the Secretary shall implement and enforce the requirements of this subtitle under subsection (c) insofar as they relate to the issuance, sale, renewal, and offering of qualified core

plans and qualified core compatible plans in such State.

(b) PROCEDURE.—

(1) PRESUMPTION.—

(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, a State is presumed to be implementing and enforcing this subtitle if, by not later than the date that is 6 months after the date of enactment of this Act, the chief executive officer of the State—

(i) notifies the Secretary that the State has enacted or intends to enact (by not later than January 1, 2009, or July 1, 2009 in the case of a State described in subparagraph (B)(ii)) any necessary legislation to provide for the implementation and enforcement of such subtitle; and

(ii) provides the Secretary with such information as the Secretary may require to review the legislation and its implementation (or proposed implementation) under this subsection.

(B) DELAY PERMITTED FOR CERTAIN STATES.—

(i) EFFECT OF DELAY.—In the case of a State described in clause (ii) that provides notice under subparagraph (A)(i), for the presumption to continue on and after July 1, 2009, the chief executive officer of the State by April 1, 2009—

(I) must notify the Secretary that the State has enacted any necessary legislation to provide for the implementation and enforcement of this subtitle as of July 1, 2009; and

(II) must provide the Secretary with such information as the Secretary may require to review the legislation and its implementation (or proposed implementation) under this subsection.

(ii) STATES DESCRIBED.—A State described in this clause is a State that has a legislature that does not meet within the 12-month period beginning on the date of enactment of this Act.

(C) CONTINUED APPLICATION.—In order for a State to continue to be presumed to be implementing and enforcing the requirements of

this subtitle, the State shall provide the Secretary every 3 years with information described in subparagraph (A)(ii) or (B)(i)(II) (as the case may be).

(2) NOTICE.—If the Secretary finds, after review of information provided under paragraph (1) and in consultation with the chief executive officer of the State and the insurance commissioner of the State, that the State is not implementing and enforcing the requirements of this subtitle, the Secretary—

(A) shall notify the State of—

(i) such preliminary determination, and

(ii) the consequences under paragraph (3) of a failure to carry out such implementation and enforcement; and

(B) shall permit the State a reasonable opportunity in which to modify State law in a manner so that may be acceptable implementation and enforcement.

(3) FINAL DETERMINATION.—If, after providing notice and opportunity under paragraph (2), the Secretary finds that the State is not implementing or enforcing the requirements of this sub-

title, the Secretary shall notify the State of such fact and that the Secretary shall be responsible for enforcing such requirements in the State.

(4) FUTURE ADOPTION OF MECHANISMS.—If a State, after the Secretary makes a notification described in paragraph (3), submits the notice and information described in paragraph (1), unless the Secretary makes a finding described in paragraph (3) within the 90-day period beginning on the date of submission of the notice and information, the mechanism shall be considered to be an acceptable alternative mechanism for purposes of this section, effective 90 days after the end of such period, subject to the second sentence of paragraph (1).

(c) SECRETARIAL ENFORCEMENT AUTHORITY.—

(1) LIMITATION.—The provisions of this subsection shall apply with respect to the enforcement of a provision (or provisions) of this subtitle only—

(A) as provided under subsection (a)(2); and

(B) with respect to health insurance issuers and qualified core plans and qualified core compatible plans.

(2) IMPOSITION OF PENALTIES.—In the cases described in paragraph (1):

(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, any health insurance issuer that fails to comply with a provision of this subtitle applicable to such issuer with respect to a qualified core plan or qualified core compatible plan is subject to a civil money penalty under this subsection.

(B) AMOUNT OF PENALTY.—

(i) IN GENERAL.—The maximum amount of penalty imposed under this paragraph is $100 for each day for each individual with respect to which such a failure occurs.

(ii) CONSIDERATIONS IN IMPOSITION.—In determining the amount of any penalty to be assessed under this paragraph, the Secretary shall take into account the previous record of compliance of the issuer being assessed with the applicable provisions of this subtitle and the gravity of the violation.

(iii) LIMITATIONS.—

(I) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILI-

GENCE.—No civil money penalty shall be imposed under this paragraph on any failure during any period for which it is established to the satisfaction of the Secretary that none of the entities against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(II) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No civil money penalty shall be imposed under this paragraph on any failure if such failure was due to reasonable cause and not to willful neglect, and such failure is corrected during the 30-day period beginning on the first day any of the entities against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(C) ADMINISTRATIVE REVIEW.—

(i) OPPORTUNITY FOR HEARING.—The entity assessed shall be afforded an

opportunity for hearing by the Secretary upon request made within 30 days after the date of the issuance of a notice of assessment. In such hearing the decision shall be made on the record pursuant to section 554 of title 5, United States Code. If no hearing is requested, the assessment shall constitute a final and unappealable order.

(ii) HEARING PROCEDURE.—If a hearing is requested, the initial agency decision shall be made by an administrative law judge, and such decision shall become the final order unless the Secretary modifies or vacates the decision. Notice of intent to modify or vacate the decision of the administrative law judge shall be issued to the parties within 30 days after the date of the decision of the judge. A final order which takes effect under this paragraph shall be subject to review only as provided under subparagraph (D).

(D) JUDICIAL REVIEW.—

(i) FILING OF ACTION FOR REVIEW.—Any entity against whom an order impos-

ing a civil money penalty has been entered after an agency hearing under this paragraph may obtain review by the United States district court for any district in which such entity is located or the United States District Court for the District of Columbia by filing a notice of appeal in such court within 30 days from the date of such order, and simultaneously sending a copy of such notice by registered mail to the Secretary.

(ii) CERTIFICATION OF ADMINISTRATIVE RECORD.—The Secretary shall promptly certify and file in such court the record upon which the penalty was imposed.

(iii) STANDARD FOR REVIEW.—The findings of the Secretary shall be set aside only if found to be unsupported by substantial evidence as provided by section 706(2)(E) of title 5, United States Code.

(iv) APPEAL.—Any final decision, order, or judgment of the district court concerning such review shall be subject to

appeal as provided in chapter 83 of title 28 of such Code.

(E) FAILURE TO PAY ASSESSMENT; MAINTENANCE OF ACTION.—

(i) FAILURE TO PAY ASSESSMENT.—If any entity fails to pay an assessment after it has become a final and unappealable order, or after the court has entered final judgment in favor of the Secretary, the Secretary shall refer the matter to the Attorney General who shall recover the amount assessed by action in the appropriate United States district court.

(ii) NONREVIEWABILITY.—In such action the validity and appropriateness of the final order imposing the penalty shall not be subject to review.

(F) PAYMENT OF PENALTIES.—Except as otherwise provided, penalties collected under this paragraph shall be paid to the Secretary (or other officer) imposing the penalty and shall be available without appropriation and until expended for the purpose of enforcing the provisions with respect to which the penalty was imposed.

(d) PREEMPTION.—

(1) IN GENERAL.—Subject to subsection (b), nothing in this subtitle shall be construed to prevent a State from establishing, implementing, or continuing in effect standards and requirements unless such standards and requirements prevent the application of a requirement of this subtitle.

(2) RULES OF CONSTRUCTION.—Except as otherwise provided for in this Act, nothing in this subtitle shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

Subtitle B—Standard Deduction for Health Insurance and Related Provisions

SEC. 121. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this subtitle an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

SEC. 122. STANDARD DEDUCTION FOR HEALTH INSURANCE.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 (relating to additional itemized deductions for individuals) is amended by redesignating section 224 as section 225 and by inserting after section 223 the following new section:

"SEC. 224. STANDARD DEDUCTION FOR HEALTH INSURANCE.

"(a) DEDUCTION ALLOWED.—In the case of an individual, there shall be allowed as a deduction to the taxpayer for the taxable year the standard deduction for health insurance.

"(b) STANDARD DEDUCTION FOR HEALTH INSURANCE.—For purposes of this section—

"(1) IN GENERAL.—The term 'standard deduction for health insurance' means the sum of the amounts determined under paragraph (2) with respect to each individual for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

"(2) ALLOWANCE FOR EACH INDIVIDUAL.—The amount determined under this paragraph with respect to any individual is the sum of the monthly

limitations for months during the taxable year that the individual is an eligible individual.

"(3) MONTHLY LIMITATION.—

"(A) IN GENERAL.—The monthly limitation for any month is 1/12 of $7,500.

"(B) COST-OF-LIVING ADJUSTMENT.—

"(i) IN GENERAL.—In the case of taxable years beginning in calendar years after the first calendar year to which this section applies, the $7,500 amount under subparagraph (A) shall be increased by an amount equal to—

"(I) such dollar amount, multiplied by

"(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins, determined by substituting 'the calendar year preceding the first calendar year to which section 224 applies' for 'calendar year 1992' in subparagraph (B) thereof.

"(ii) ROUNDING.—If any increase under clause (i) is not a multiple of $50,

such increase shall be rounded to the nearest multiple of $50.

"(c) LIMITATIONS AND SPECIAL RULES RELATING TO STANDARD DEDUCTION.—For purposes of this section—

"(1) ONLY 2 ELIGIBLE INDIVIDUALS TAKEN INTO ACCOUNT.—A taxpayer shall not take into account more than 2 eligible individuals for any month in computing the standard deduction for health insurance for purposes of subsection (a).

"(2) SPECIAL RULE FOR MARRIED INDIVIDUALS FILING SEPARATELY.—In the case of a married individual who files a separate return for the taxable year, the deduction allowed under subsection (a) shall be equal to one-half of the amount which would otherwise be determined under subsection (a) if such individual filed a joint return for the taxable year.

"(3) DENIAL OF DEDUCTION TO DEPENDENTS.—No deduction shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

"(4) COORDINATION WITH OTHER HEALTH TAX INCENTIVES.—

"(A) DENIAL OF DEDUCTION IF HEALTH INSURANCE COSTS CREDIT ALLOWED.—No deduction shall be allowed under this section to any taxpayer if a credit is allowed to the taxpayer under section 35 or 36 for the taxable year.

"(B) REDUCTION FOR INSURANCE PURCHASED WITH MSA OR HSA FUNDS.—The amount allowed as a deduction under subsection (a) for the taxable year shall be reduced by the aggregate amount—

"(i) paid during the taxable year from an Archer MSA to which section 220(d)(2)(B)(ii) (other than subclause (II) thereof) applies, and

"(ii) paid during the taxable year from a health savings account to which section 223(d)(2)(C) (other than clause (ii) thereof) applies.

"(5) SPECIAL RULE FOR DIVORCED PARENTS, ETC.—Notwithstanding subsection (b)(1), an individual who is a child may be taken into account on the return of the parent other than the parent for

whom a deduction with respect to the child is allowed under section 151 for a taxable year beginning in a calendar year if—

"(A) the parent for whom the deduction under section 151 is allowed for a taxable year beginning in such calendar year signs a written declaration (in such manner and form as the Secretary may by regulations prescribe) that such parent will not claim the deduction allowable under this section with respect to the child for taxable years beginning in such calendar year, and

"(B) the parent for whom the deduction under section 151 is not allowed attaches such written declaration to the parent's return for the taxable year beginning in such calendar year.

"(d) OTHER DEFINITIONS.—For purposes of this section—

"(1) ELIGIBLE INDIVIDUAL.—

"(A) IN GENERAL.—The term 'eligible individual' means, with respect to any month, an individual who is covered under a qualified health plan as of the 1st day of such month.

"(B) COVERAGE UNDER MEDICARE, MEDICAID, OR SCHIP AND GRANDFATHERED EMPLOYER COVERAGE.—The term 'eligible individual' shall not include any individual who for any month is—

"(i) entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title,

"(ii) enrolled in the program under title XIX or XXI of such Act (other than under section 1928 of such Act), or

"(iii) receiving benefits (other than under continuation coverage under section 4980B) which constitute medical care from an employer—

"(I) from whom such individual is separated from service at the time of receipt of such benefits, and

"(II) after such separation, if such benefits began before January 1, 2010,

unless such individual is also covered by a qualified health plan as of the 1st day of such month.

"(C) IDENTIFICATION REQUIREMENTS.—The term 'eligible individual' shall not include any individual for any month unless the policy number associated with coverage under the qualified health plan and the TIN of each eligible individual covered under such coverage for such month is included on the return for the taxable year in which such month occurs.

"(2) QUALIFIED HEALTH PLAN.—

"(A) IN GENERAL.—The term 'qualified health plan' means a health plan (within the meaning of section 223(c)(2), without regard to subparagraph (A)(i) thereof) which, under regulations prescribed by the Secretary, meets the following requirements:

"(i) The plan has a reasonable annual or lifetime benefit maximum.

"(ii) The plan has coverage for inpatient and outpatient care, emergency benefits, and physician care.

"(iii) No pre-existing condition limitations are imposed with respect to any eligible individual.

"(iv) The plan has coverage which meaningfully limits individual economic exposure to extraordinary medical expenses

"(B) EXCLUSION OF CERTAIN PLANS.—The term 'qualified health plan' does not include—

"(i) a health plan if substantially all of its coverage is coverage described in section 223(c)(1)(B),

"(ii) any program or benefits referred to in clause (i), (ii), or (iii) of paragraph (1)(B), and

"(iii) a medicare supplemental policy (as defined in section 1882 of the Social Security Act).

"(e) REGULATIONS.—The Secretary may prescribe such regulations as may be necessary to carry out this section.".

(b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 is amended by inserting before the last sentence at the end the following new paragraph:

"(22) STANDARD DEDUCTION FOR HEALTH INSURANCE.—The deduction allowed by section 224.".

(c) ELECTION TO TAKE HEALTH INSURANCE COSTS CREDIT.—Section 35(g) (relating to special rules for credit for health insurance costs of eligible individuals) is amended by redesignating paragraph (9) as paragraph (10) and by inserting after paragraph (8) the following new paragraph:

"(9) ELECTION NOT TO CLAIM CREDIT.—This section shall not apply to a taxpayer for any taxable year if such taxpayer elects to have this section not apply for such taxable year.".

(d) CLERICAL AMENDMENT.—The table of sections for part VII of subchapter B of chapter 1 is amended by striking the item relating to section 224 and adding at the end the following new items:

"Sec. 224. Standard deduction for health insurance.
"Sec. 225. Cross reference.".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning on or after the first day of the first calendar year in which occurs the first date on which the requirement of section 101(a) of this Act applies.

SEC. 123. CHANGES TO EXISTING TAX PREFERENCES FOR MEDICAL COVERAGE AND COSTS FOR INDIVIDUALS ELIGIBLE FOR STANDARD DEDUCTION FOR HEALTH INSURANCE.

(a) DEDUCTION FOR MEDICAL, DENTAL, ETC., EXPENSES.—Section 213 (relating to medical, dental, etc., expenses) is amended by adding at the end the following new subsection:

"(f) TERMINATION OF DEDUCTION FOR INDIVIDUALS NOT COVERED BY MEDICARE, MEDICAID, SCHIP, OR GRANDFATHERED EMPLOYER PLANS.—

"(1) IN GENERAL.—Except as provided in paragraph (2), no deduction shall be allowed under subsection (a) for any taxable year with respect to which a deduction under section 224 is allowable.

"(2) EXCEPTION FOR INDIVIDUALS COVERED BY MEDICARE, MEDICAID, SCHIP, OR GRANDFATHERED EMPLOYER PLANS.—Paragraph (1) shall not apply to an individual for any taxable year if such individual is not an eligible individual (as defined in section 224(d)(1)) for any month during such taxable year by reason of coverage described in section 224(d)(1)(B).".

(b) EXCLUSION FOR CONTRIBUTIONS BY EMPLOYER TO ACCIDENT AND HEALTH PLANS.—

(1) IN GENERAL.—Section 106 (relating to contributions by employer to accident and health plans) is amended by adding at the end the following new subsection:

"(f) SUBSECTIONS (a) AND (c) APPLY ONLY TO INDIVIDUALS COVERED BY MEDICARE, MEDICAID, SCHIP, OR GRANDFATHERED EMPLOYER PLANS.—

"(1) IN GENERAL.—Except as provided in paragraph (2), subsections (a) and (c) shall not apply for any taxable year with respect to which a deduction under section 224 is allowable.

"(2) EXCEPTION FOR INDIVIDUALS COVERED BY MEDICARE, MEDICAID, SCHIP, OR GRANDFATHERED EMPLOYER PLANS.—Paragraph (1) shall not apply to an individual for any taxable year if such individual is not an eligible individual (as defined in section 224(d)(1)) for any month during such taxable year by reason of coverage described in section 224(d)(1)(B).".

(2) CONFORMING AMENDMENTS.—

(A) Section 106(b)(1) is amended—

(i) by inserting "gross income does not include" before "amounts contributed", and

(ii) by striking "shall be treated as employer-provided coverage for medical expenses under an accident or health plan".

(B) Section 106(d)(1) is amended—

(i) by inserting "gross income does not include" before "amounts contributed", and

(ii) by striking "shall be treated as employer-provided coverage for medical expenses under an accident or health plan".

(c) AMOUNTS RECEIVED UNDER ACCIDENT AND HEALTH PLANS.—

(1) IN GENERAL.—Section 105 (relating to amounts received under accident and health plans) is amended by adding at the end the following new subsection:

"(j) SECTION ONLY TO APPLY TO INDIVIDUALS COVERED BY MEDICARE, MEDICAID, SCHIP, OR GRANDFATHERED EMPLOYER PLANS.—

"(1) IN GENERAL.—Except as provided in paragraph (2), subsection (b) shall not apply for any taxable year with respect to which a deduction under section 224 is allowable.

"(2) EXCEPTION FOR INDIVIDUALS COVERED BY MEDICARE, MEDICAID, SCHIP, OR GRAND-

FATHERED EMPLOYER PLANS.—Paragraph (1) shall not apply to an individual for any taxable year if such individual is not an eligible individual (as defined in section 224(d)(1)) for any month during such taxable year by reason of coverage described in section 224(d)(1)(B).".

(d) TERMINATION OF DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.—Subsection (l) of section 162 (relating to special rules for health insurance costs of self-employed individuals) is amended by adding at the end the following new paragraph:

"(6) TERMINATION.—This subsection shall not apply to taxable years with respect to which a deduction under section 224 is allowable.".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning on or after the first day of the first calendar year in which occurs the first date on which the requirement of section 101(a) of this Act applies.

SEC. 124. EXCLUSION OF STANDARD DEDUCTION FOR HEALTH INSURANCE FROM EMPLOYMENT TAXES.

(a) IN GENERAL.—Chapter 25 (relating to general provisions relating to employment taxes) is amended by adding at the end the following new section:

"SEC. 3511. EXCLUSION OF STANDARD DEDUCTION FROM EMPLOYMENT TAXES.

"(a) IN GENERAL.—For purposes of chapters 21, 22, and 23, each of the following amounts for any period (determined without regard to this section) shall be reduced by the portion of the standard deduction for health insurance (as defined in section 224) allocable to the period:

"(1) The amount of wages determined under section 3121(a).

"(2) The amount of compensation determined under section 3231(e).

"(3) The amount of wages determined under section 3306(b).

"(b) DETERMINATION OF STANDARD DEDUCTION ALLOCABLE TO A PERIOD.—For purposes of subsection (a)—

"(1) IN GENERAL.—The determination of the portion of the standard deduction for health insurance allocable to a period shall be made on the basis

of a qualified certificate of eligible coverage furnished by the employee to the employer.

"(2) QUALIFIED CERTIFICATE OF ELIGIBLE COVERAGE.—The term 'qualified certificate of eligible coverage' means a statement of eligibility for the deduction allowable under section 224 which contains such information, is in such form, and is provided at such times, as the Secretary may prescribe.

"(3) ONLY 1 CERTIFICATE IN EFFECT AT A TIME.—Except as provided by the Secretary, an employee may have only 1 qualified certificate of eligible coverage in effect for any period.

"(4) ELECTION.—An employee may elect not to have this section apply for any period for purposes of chapter 21 or 22.

"(c) RECONCILIATION OF ERRONEOUS PAYMENTS TO BE MADE AT EMPLOYEE LEVEL.—

"(1) IN GENERAL.—If the application of this subsection results in an incorrect amount being treated as wages or compensation for purposes of chapter 21, 22, or 23, whichever is applicable, with respect to any employee for 1 or more periods ending within a taxable year of the employee—

"(A) in the case of an aggregate overpayment of the taxes imposed by any such chapter

for all such periods, there shall be allowed as a credit against the tax imposed by chapter 1 for such taxable year on such employee an amount equal to the amount of such overpayment, and

"(B) in the case of an aggregate underpayment of the taxes imposed by any such chapter for all such periods, the employee shall be liable for payment of the entire amount of such underpayment.

"(2) CREDITS TREATED AS REFUNDABLE.—For purposes of this title, any credit determined under paragraph (1)(A) or subsection (d)(2) shall be treated as if it were a credit allowed under subpart C of part IV of subchapter A of chapter 1.

"(3) RULES FOR REPORTING AND COLLECTION OF TAX.—Any tax required to be paid by an employee under paragraph (1)(B) shall be included with the employee's return of Federal income tax for the taxable year.

"(4) SECRETARIAL AUTHORITY.—The Secretary shall prescribe such rules as may be necessary to carry out the provisions of this subsection.

"(d) PHASE IN.—

"(1) IN GENERAL.—In the case of the first 3 calendar years to which this section applies, sub-

section (a) shall apply to wages and compensation of an employee only for purposes of section 3101, 3201, 3211, or 3301, whichever is applicable.

"(2) CREDIT.—In the case of any taxable year beginning in a calendar year to which paragraph (1) applies, there shall be allowed as a credit against the tax imposed by chapter 1 for such taxable year on an employee an amount equal to the excess of—

"(A) the tax imposed under section 3111 or 3231, whichever is applicable, on the wages of the employee for the part of such calendar year in such taxable year, over

"(B) the tax which would have been imposed under section 3111 or 3231, whichever is applicable, on the wages of the employee for the part of such calendar year in such taxable year if subsection (a) had applied for purposes of section 3111 or 3231.".

(b) SELF-EMPLOYMENT INCOME.—Section 1402 (defining net earnings from self-employment) is amended by adding at the end the following:

"(l) STANDARD DEDUCTION FOR HEALTH INSURANCE.—For purposes of this chapter—

"(1) IN GENERAL.—The self-employment income of a taxpayer for any period (determined with-

out regard to this subsection) shall be reduced by the excess (if any) of—

"(A) the portion of the standard deduction for health insurance (as defined in section 224) allocable to the period, over

"(B) the amount of any reduction in wages or compensation for such period under section 3511.

"(2) DETERMINATION OF STANDARD DEDUCTION ALLOCABLE TO A PERIOD.—For purposes of paragraph (1), the portion of the standard deduction allocable to any period shall be determined in a manner similar to the manner under section 3511.".

(c) CONFORMING AMENDMENTS.—

(1) Section 3121(a)(2) is amended by inserting "which is excludable from gross income under section 105 or 106" after "such payment)".

(2) Subsection (a) of section 209 of the Social Security Act (42 U.S.C. 409) is amended by striking "or" at the end of paragraph (18), by striking the period at the end of paragraph (19) and inserting "; or", and by inserting after paragraph (19) the following new paragraph:

"(20) any amount excluded from wages under section 3511(a) of the Internal Revenue Code of

1986 (relating to exclusion of standard deduction from employment taxes).".

(3) Section 1324(b)(2) of title 31, United States Code, is amended by inserting ", or the credit under section 3511(c)(2) of such Code" before the period at the end.

(4) Section 209(k)(2) of the Social Security Act is amended by redesignating subparagraphs (C) and (D) as subparagraphs (D) and (E), respectively, and by inserting after subparagraph (B) the following new subparagraph:

"(C) by disregarding the exclusion from wages in subsection (a)(20),".

(5) The table of sections for chapter 25 is amended by adding at the end the following new item:

"Sec. 3511. Exclusion of standard deduction from employment taxes.".

(d) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to remuneration paid or accrued for periods on or after the first day of the first calendar year in which occurs the first date on which the requirement of section 101(a) of this Act applies.

(2) RECONCILIATION AND SELF-EMPLOYED.—Sections 3511(c) and (d)(2) of the Internal Revenue

Code of 1986 (as added by subsection (a)), and the amendments made by subsection (b), shall apply to taxable years beginning on or after the first day described in paragraph (1).

SEC. 125. INFORMATION REPORTING.

(a) HEALTH PLAN PROVIDERS.—Subpart B of part III of subchapter A of chapter 61 (relating to information concerning transactions with other persons) is amended by adding at the end the following new section:

"SEC. 6050W. COVERAGE UNDER QUALIFIED HEALTH PLAN.

"(a) IN GENERAL.—Every person providing coverage under a qualified health plan (as defined in section 224(d)(2)) during a calendar year shall, on or before January 31 of the succeeding year, make a return described in subsection (b) with respect to each individual who is covered by such person under a qualified health plan for any month during the calendar year.

"(b) RETURN.—A return is described in this subsection if such return—

"(1) is in such form as the Secretary prescribes, and

"(2) contains—

"(A) the name of the person providing coverage under the qualified health plan,

"(B) the name, address, and TIN of the individual covered by the plan,

"(C) if such individual is the owner of the policy under which such plan is provided, the name, address, and TIN of each other individual covered by such policy and the relationship of each such individual to such owner, and

"(D) the specific months of the year for which each individual referred to in subparagraph (B) is, as of the first day of each such month, covered by such plan.

"(c) STATEMENT TO BE FURNISHED WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return under subsection (b)(2)(A) a written statement showing—

"(1) the name, address, and phone number of the information contact of the person required to make such return, and

"(2) the information described in subsection (b)(2).

The written statement required under the preceding sentence shall be furnished on or before January 31 of the

year following the calendar year for which the return under subsection (a) was required to be made.".

(b) EMPLOYERS.—Subsection (a) of section 6051 (relating to requirement for employers to provide W-2 information) is amended by striking "and" at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting ", and", and by inserting after paragraph (13) the following new paragraph:

"(14) the value (determined under section 4980B(f)(4)) of employer-provided coverage for each month under an accident or health plan and the category of such coverage for purposes of section 6116.".

(c) APPLICATION TO RETIREES.—Subsection (a) of section 6051 is amended by adding at the end the following: "In the case of a retiree, this section shall (to the extent established by the Secretary by regulation) apply only with respect to paragraph (14).".

(d) ASSESSABLE PENALTIES.—

(1) Subparagraph (B) of section 6724(d)(1) of such Code (relating to definitions) is amended by redesignating clauses (xv) through (xx) as clauses (xvi) through (xxi), respectively, and by inserting after clause (xi) the following new clause:

"(xv) section 6050W (relating to returns relating to payments for qualified health insurance),".

(2) Paragraph (2) of section 6724(d) of such Code is amended by striking the period at the end of subparagraph (CC) and inserting ", or" and by adding at the end the following new subparagraph:

"(DD) section 6050W(d) (relating to returns relating to payments for qualified health insurance).".

(e) CLERICAL AMENDMENT.—The table of sections for such subpart B is amended by adding at the end the following new item:

"Sec. 6050W. Coverage under qualified health plan.".

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to years beginning on or after the first day of the first calendar year in which occurs the first date on which the requirement of section 101(a) of this Act applies.

SEC. 126. REDUCTION OF PHASEOUT FOR EARNED INCOME CREDIT.

(a) IN GENERAL.—Paragraph (1) of section 32(b) (relating to percentages) is amended—

(1) in subparagraph (A)—

(A) by striking "15.98" and inserting "15", and

(B) by striking "21.06" and inserting "15",

(2) in subparagraph (B)—

(A) by striking "15.98" and inserting "15", and

(B) by striking "20.22" and inserting "15", and

(3) in subparagraph (C)—

(A) by striking "15.98" and inserting "15", and

(B) by striking "17.68" and inserting "15".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to taxable years beginning on or after the first day of the first calendar year in which occurs the first date on which the requirement of section 101(a) of this Act applies.

Subtitle C—Health Insurance Tax Credit for the Purchase of Health Insurance

PART I—REFUNDABLE HEALTH INSURANCE TAX CREDIT

SEC. 131. REFUNDABLE CREDIT FOR HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by redesignating section 36 as section 37 and by inserting after section 35 the following new section:

"SEC. 36. REFUNDABLE CREDIT FOR HEALTH INSURANCE COVERAGE.

"(a) IN GENERAL.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this subtitle an amount equal to the health insurance credit amount of the taxpayer for the taxable year.

"(b) HEALTH INSURANCE CREDIT AMOUNT.—For purposes of this section—

"(1) IN GENERAL.—The term 'health insurance credit amount' means, with respect to any taxable year, the lesser of—

"(A) the sum of the amounts determined under paragraph (2) with respect to each indi-

vidual for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year, or

"(B) an amount equal to twice the individual annual limit in effect for the taxable year under paragraph (3).

"(2) ALLOWANCE FOR EACH INDIVIDUAL.—The amount determined under this paragraph with respect to any individual is the sum of the monthly limitations for coverage months of the individual occurring during the taxable year.

"(3) MONTHLY LIMITATION.—

"(A) IN GENERAL.—The monthly limitation for any month is 1/12 of the individual annual limit for the taxable year.

"(B) INDIVIDUAL ANNUAL LIMIT.—The individual annual limit is $2,500.

"(C) COST-OF-LIVING ADJUSTMENT.—

"(i) IN GENERAL.—In the case of taxable years beginning in calendar years after the first calendar year to which this section applies, the $2,500 amount under subparagraph (B) shall be increased by an amount equal to—

"(I) such dollar amount, multiplied by

"(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins, determined by substituting 'the calendar year preceding the first calendar year to which section 36 applies' for 'calendar year 1992' in subparagraph (B) thereof.

"(ii) ROUNDING.—If any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.

"(4) COVERAGE MONTH.—For purposes of this subsection—

"(A) IN GENERAL.—The term 'coverage month' means, with respect to an individual, any month if—

"(i) as of the first day of such month such individual is covered by qualified health insurance, and

"(ii) the premium for coverage under such insurance for such month is paid by the taxpayer.

"(B) EXCEPTION FOR EMPLOYER-SUBSIDIZED COVERAGE.—If an individual is eligible to participate for any month in any subsidized health plan maintained by any employer of the taxpayer or the taxpayer's spouse, such month shall not be treated as a coverage month with respect to the individual.

"(C) EXCEPTION FOR CERTAIN GOVERNMENTAL COVERAGE.—The term 'coverage month' shall not include any month with respect to an individual if for such month the individual is—

"(i) entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title,

"(ii) enrolled in the program under title XIX or XXI of such Act (other than under section 1928 of such Act), unless the individual has elected under such program to be enrolled for coverage under qualified health insurance for the month in lieu of coverage under such program, or

"(iii) is entitled to any benefit under—

"(I) chapter 55 of title 10, United States Code,

"(II) chapter 17 of title 38, United States Code, or

"(III) any medical care program under the Indian Health Care Improvement Act.

"(D) PRISONERS.—The term 'coverage month' shall not include any month with respect to an individual if for such month the individual is imprisoned under Federal, State, or local authority for a period of at least 1 month.

"(E) INSUFFICIENT PRESENCE IN UNITED STATES.—The term 'coverage month' shall not include any month during a taxable year with respect to an individual if such individual is present in the United States on fewer than 183 days during such year (determined in accordance with section 7701(b)(7)).

"(c) LIMITATIONS.—

"(1) PHASEOUT OF CREDIT BASED ON ADJUSTED GROSS INCOME.—

"(A) IN GENERAL.—If the taxpayer's modified adjusted gross income exceeds the applicable threshold amount for any taxable year,

the amount allowed as a credit under subsection (a) (determined without regard to this paragraph) shall be reduced (but not below zero) by the amount which bears the same ratio to such amount as such excess bears to an amount equal to the difference between the applicable threshold amount and 300 percent of the applicable threshold amount.

"(B) APPLICABLE THRESHOLD AMOUNT.—For purposes of subparagraph (A), the applicable threshold amount for a taxable year shall be determined in accordance with the following table:

"If the number of personal exemptions is:	The applicable threshold amount is:
1	$10,210
2	$13,690
3	$17,170
4 or more	$20,650

"(C) PERSONAL EXEMPTIONS.—For purposes of subparagraph (B), the number of personal exemptions of a taxpayer is equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

"(D) COST-OF-LIVING ADJUSTMENT.—

"(i) IN GENERAL.—In the case of taxable years beginning in calendar years after the first calendar year to which this section applies, each of the dollar amounts in the table under subparagraph (B) shall be increased by an amount equal to—

"(I) such dollar amount, multiplied by

"(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins, determined by substituting 'the calendar year preceding the first calendar year to which section 36 applies' for 'calendar year 1992' in subparagraph (B) thereof.

"(ii) ROUNDING.—If any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.

"(E) MODIFIED ADJUSTED GROSS INCOME.—The term 'modified adjusted gross income' means adjusted gross income determined—

"(i) without regard to sections 911, 931, and 933, and

"(ii) after application of sections 86, 135, 137, 219, 221, and 469.

"(2) IDENTIFICATION REQUIREMENTS.—No credit shall be allowed under subsection (a) for any coverage month with respect to an individual unless the policy number associated with coverage under the qualified health plan and the TIN of the individual covered under such coverage for such month is included on the return for the taxable year in which such month occurs.

"(d) QUALIFIED HEALTH INSURANCE.—For purposes of this section, the term 'qualified health insurance' means coverage under—

"(1) a qualified core plan certified under section 102 of the Ten Steps to Transform Health Care in America Act , and

"(2) any plan certified under section 103 of such Act as a qualified core compatible plan with respect to a qualified core plan.

"(e) ARCHER MSA AND HEALTH SAVINGS ACCOUNT CONTRIBUTIONS.—

"(1) IN GENERAL.—If a deduction would (but for paragraph (2)) be allowed under section 220 or

223 to the taxpayer for a payment for the taxable year to the Archer MSA or health savings account of an individual established in connection with qualified health insurance, subsection (a) shall be applied by treating such payment as a payment for qualified health insurance for such individual.

"(2) DENIAL OF DOUBLE BENEFIT.—No deduction shall be allowed under section 220 or 223 for that portion of the payments otherwise allowable as a deduction under section 220 or 223 for the taxable year which is equal to the amount of credit allowed for such taxable year by reason of this subsection.

"(f) SPECIAL RULES.—For purposes of this section—

"(1) MARRIED COUPLES MUST FILE JOINT RETURN.—If the taxpayer is married at the close of the taxable year, the credit shall be allowed under subsection (a) only if the taxpayer and the taxpayer's spouse file a joint return for the taxable year.

"(2) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a tax-

able year beginning in the calendar year in which such individual's taxable year begins.

"(3) DENIAL OF DOUBLE BENEFIT.—No credit shall be allowed under subsection (a) if the credit under section 35 is allowed and no credit shall be allowed under 35 if a credit is allowed under this section.

"(4) SPECIAL RULE FOR DIVORCED PARENTS, ETC.—A rule similar to the rule of section 224(c)(5) shall apply for purposes of this section.

"(5) ELECTION NOT TO CLAIM CREDIT.—This section shall not apply to a taxpayer for any taxable year if such taxpayer elects to have this section not apply for such taxable year.".

(b) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting before the period ", or from section 36 of such Code".

(2) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by striking the last item and inserting the following new items:

"Sec. 36. Refundable credit for health insurance coverage.
"Sec. 37. Overpayments of tax.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning on or

after the first day of the first calendar year in which occurs the first date on which the requirement of section 101(a) of this Act applies.

SEC. 132. ADVANCE PAYMENT OF CREDIT FOR PURCHASERS OF QUALIFIED HEALTH INSURANCE.

(a) IN GENERAL.—Chapter 77 of the Internal Revenue Code of 1986 (relating to miscellaneous provisions) is amended by adding at the end the following new section:

"SEC. 7529. ADVANCE PAYMENT OF CREDIT FOR PURCHASERS OF QUALIFIED HEALTH INSURANCE.

"(a) GENERAL RULE.—In the case of an eligible individual, the Secretary shall make payments to the provider of such individual's qualified health insurance equal to such individual's qualified health insurance credit advance amount with respect to such provider.

"(b) ELIGIBLE INDIVIDUAL.—For purposes of this section, the term 'eligible individual' means any individual—

"(1) who purchases qualified health insurance (as defined in section 36(d)), and

"(2) for whom a qualified health insurance credit eligibility certificate is in effect.

"(c) QUALIFIED HEALTH INSURANCE CREDIT ELIGIBILITY CERTIFICATE.—For purposes of this section, a qualified health insurance credit eligibility certificate is a statement furnished by an individual to the Secretary which—

"(1) certifies that the individual will be eligible to receive the credit provided by section 36 for the taxable year,

"(2) estimates the amount of such credit for such taxable year, and

"(3) provides such other information as the Secretary may require for purposes of this section.

"(d) QUALIFIED HEALTH INSURANCE CREDIT ADVANCE AMOUNT.—For purposes of this section, the term 'qualified health insurance credit advance amount' means, with respect to any provider of qualified health insurance, the lesser of—

"(1) the Secretary's estimate of the amount of credit allowable under section 36 to the individual for the taxable year which is attributable to the insurance provided to the individual by such provider, or

"(2) the aggregate premiums with respect to such insurance for months occurring during such taxable year.

"(e) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this section.".

(b) CLERICAL AMENDMENT.—The table of sections for chapter 77 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

"Sec. 7529. Advance payment of credit for purchasers of qualified health insurance.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning on or after the first day of the first calendar year in which occurs the first date on which the requirement of section 101(a) of this Act applies.

SEC. 133. DESIGNATION OF HEALTH INSURANCE STATUS REQUIRED BY INDIVIDUALS ON FEDERAL INCOME TAX RETURNS.

(a) IN GENERAL.—Subchapter B of chapter 61 of the Internal Revenue Code of 1986 (relating to miscellaneous provisions involving information and returns) is amended by redesignating section 6116 as section 6117 and by inserting after section 6115 the following new section:

"SEC. 6116. DESIGNATION OF HEALTH INSURANCE STATUS REQUIRED BY INDIVIDUALS ON FEDERAL INCOME TAX RETURNS.

"(a) GENERAL RULE.—In the case of an individual, if a taxpayer is required to file a return of tax imposed

by chapter 1 for such taxable year, the taxpayer shall include with such return the designation described in subsection (b) with respect to the taxpayer and the spouse or any dependent of the taxpayer with respect to whom a deduction under section 151 is allowed to the taxpayer for the taxable year.

"(b) DESIGNATION.—

"(1) IN GENERAL.—The taxpayer shall designate with respect to each individual described in subsection (a) which of the following categories of health insurance coverage is applicable to the individual as of the close of the taxable year for which the return is being filed:

"(A) Coverage under a qualified health plan (as defined in section 224(d)(2).

"(B) Coverage under qualified health insurance (as defined in section 36(d)).

"(C) Coverage under an employer-sponsored health plan which is licensed and regulated by the State in which the individual resides.

"(D) Coverage under an employer-sponsored, self-insured health plan which meets the requirements of the Employee Retirement In-

come Security Act of 1974 and any other applicable law.

"(E) Coverage described in clause (i), (ii), or (iii) of section 224(d)(1)(B) (relating to coverage under medicare, medicaid, schip or grandfathered employer coverage).

"(F) Coverage not described in any of the preceding subparagraphs.

"(G) No coverage.

"(2) FORM AND MANNER.—The Secretary shall prescribe the form and manner of making the designation under this section.".

(b) CONFORMING AMENDMENTS.—The table of sections for subchapter B of chapter 61 of such Code is amended by striking the item relating to section 6116 and inserting the following new items:

"Sec. 6116. Designation of health insurance status required by individuals on Federal income tax returns.
"Sec. 6117. Cross reference.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning in—

(1) the calendar year preceding the first calendar year in which occurs the first date on which the requirement of section 101(a) of this Act applies, and

(2) any calendar year following the calendar year described in paragraph (1).

Subtitle D—Education and Outreach

SEC. 141. NOTICE TO TAXPAYERS OF AVAILABILITY OF STANDARD DEDUCTION FOR HEALTH INSURANCE AND REFUNDABLE HEALTH INSURANCE CREDIT.

The Secretary of the Treasury or the Secretary's delegate shall ensure that—

(1) any instructions booklet accompanying an individual Federal income tax return form (including forms 1040, 1040A, 1040EZ, and any similar or successor forms) , and

(2) any other publication, announcement, or website that the Secretary or the Secretary's delegate considers appropriate,

shall include, in clear language, in conspicuous print, and in a conspicuous place, information with respect to the availability of the standard deduction for health insurance or the health insurance tax credit for individuals enrolled in qualified core health plans and qualified core compatible plans certified as meeting the requirements of this Act. The requirement of this section shall apply with respect to booklets, publications, announcements, or information on websites made available on and after the date that is

1 year before the first date on which the coverage require-
ment under section 101(a) of this Act becomes effective.

SEC. 142. OPTIONAL ENROLLMENT AND OUTREACH.

(a) OPTION FOR MEDICAID OR SCHIP ELIGIBLE INDIVIDUALS TO ENROLL IN A QUALIFIED CORE PLAN.—The Secretary of Health and Human Services, in consultation with the Secretary of the Treasury and the States, shall establish a process for permitting an individual who is eligible for medical assistance under a State plan or waiver under title XIX of the Social Security Act, or for child health assistance or other health benefits coverage under a State child health plan or waiver under title XXI of such Act, to elect to enroll (or in the case of an individual who is a child under age 18, for the individual's family to elect to be enrolled) in a qualified core plan offered in the State of residence of the individual in lieu of being enrolled in such State plan or waiver for the year. The process established pursuant to this subsection shall—

(1) allow for such an election to be made on an annual basis;

(2) require the State of residence of the individual to notify the Secretary of Health and Human Services and the Secretary of the Treasury of the actuarial value of the benefits and cost-sharing pro-

tection that would have been provided to the individual under the State plan or waiver under title XIX or XXI of the Social Security Act for the year;

(3) allow for an increase in the refundable credit established under section 36 of the Internal Revenue Code of 1986 for the year in an amount equal to the actuarial value determined for purposes of paragraph (2); and

(4) require, as a condition of the continued approval of such State plans or waivers, for the Secretary of Health and Human Services to reduce the amount to be paid to the State of residence of the individual under section 1903(a) or 2105(a) of the Social Security Act (as appropriate) for each calendar quarter occurring during the year for which such credit applies by an amount equal to ¼ of the State share of the amount described in paragraph (3).

(b) ADDITIONAL OUTREACH.—

(1) ESTABLISHMENT OF OUTREACH PROGRAM.—Not later than 1 year after the date of enactment of this Act. the Secretary of Health and Human Services, in consultation with the Secretary of the Treasury, the States, and representatives of community health centers, hospitals, and other

health care providers, shall establish a program under which the Secretary of Health and Human Services shall provide access to informational materials regarding the standard deduction for health insurance established under section 224 of the Internal Revenue Code of 1986 and the refundable credit established under section 36 of such Code, including State-specific contact information for more detailed information and assistance, through health care providers and a national Internet website that meets the requirements of paragraph (1).

(2) TARGETING OF HEALTH CARE PROVIDERS THAT SERVE THE UNINSURED AND THE UNDER INSURED.—The program established under paragraph (1) shall give priority to disseminating such information through those health care providers that primarily serve uninsured or under insured individuals.

(3) NATIONAL INFORMATION WEBSITE.—For purposes of paragraph (1), the requirements of this subparagraph are that the Secretary of Health and Human Services establishes a one-stop website that provides information on the standard deduction for health insurance established under section 224 of the Internal Revenue Code of 1986 and the health

insurance tax credit established under section 36 of Code. The website shall—

(A) include significant timelines for action, a general description of enrollment processes, and links to State insurance commissioners' sites, which approve qualified core plans and shall provide a portal for comparison of such plans with respect to each State; and

(B) provide such information in a manner that—

(i) is concise, clear, and easy to understand;

(ii) allows the information to be accessed in a downloadable format;

(iii) provides appropriate links or contacts for further information; and

(iv) allows for use by providers in order to inform consumers at the point of delivery of health care items and services.

TITLE II—INCREASING INSURANCE MARKET PORTABILITY AND AFFORDABILITY

Subtitle A—Merging and Improving Insurance Markets

SEC. 201. DEVELOPMENT OF MERGED AND IMPROVED STATE INSURANCE MARKET STANDARDS.

(a) IN GENERAL.—The Secretary, in consultation with State insurance commissioners and the National Association of Insurance Commissioners, shall promulgate regulations providing for the establishment in each State of a single market for all health plans (other than self-funded plans or Federal or State governmental health coverage programs) offered in each State.

(b) REQUIREMENTS.—The regulations promulgated under subsection (a) shall, with respect to each State, require—

(1) that State health insurance laws applicable to the small group market in the State be modified, except as provided for otherwise in this Act, to apply to all health plans offered in the State regardless of whether such plans are being purchased for the coverage of individuals or for groups;

(2) that the provisions of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg

et seq.) (relating to group market rules) shall apply to all health plans offered in the State, subject to such modification as may be necessary to clarify and effectuate the application of such rules to all such health plans;

(3) that the provisions of part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–41 et seq.) (relating to individual market rules), and any other provisions or definitions within such title XXVII that apply independent standards to individual insurance markets or that relate to the relationship between such markets and group markets, shall be superseded by the provisions of this Act and shall have no force or effect; and

(4) that each health plan offered in the State fully comply with all standards provided for in this subsection, and that such standards, if not provided for otherwise in this Act, shall include requirements that each health plan—

(A) must accept for enrollment under such plan every eligible individual who applies for enrollment during the period in which the individual first becomes eligible to enroll in such plan and may not place any restriction which is inconsistent with section 2702 or 2711 of the

Public Health Service Act (42 U.S.C. 300gg–1 and 300gg–11) on an eligible individual enrolling in such plan;

(B) must renew or continue in force coverage under such plan at the option of the enrollee in accordance with section 2712 of such Act (42 U.S.C. 300gg–12);

(C) must ensure that there is no re-underwriting of such plan; and

(D) must comply with the portability requirements of section 2701 of such Act (42 U.S.C. 300gg);

(5) that the State comply with the regulations promulgated under section 211(d) with respect to reducing the effect of such material risk selection as may occur among health plans (including self-insured plans) through the establishment of State-based risk adjustment requirements.

SEC. 202. MODIFICATIONS RELATING TO SELF-FUNDED GROUP HEALTH PLANS.

(a) ERISA.—Section 734 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191c) is amended—

(1) by striking "The Secretary" and inserting the following:

"(a) IN GENERAL.—The Secretary"; and

(2) by adding at the end the following:

"(b) MODIFICATION RELATING TO THE ELIMINATION OF THE INDIVIDUAL MARKETS.—

"(1) IN GENERAL.—The Secretary shall promulgate regulations, or modify existing regulations, under this part as the Secretary determines necessary to reflect changes in State law pursuant to the Ten Steps to Transform Health Care in America Act (and the amendments made by that Act) with respect to the treatment of individual State health insurance markets and to ensure the continued application of this part to self-funded group health plans notwithstanding such changes.

"(2) CLARIFICATIONS.—The regulations or modification promulgated under paragraph (1) shall not be construed as otherwise materially altering the provisions of this part as such provisions apply to self-funded group health plans. Nothing in this subsection shall be construed to preempt the application of State insurance laws with respect to State regulated health insurance products.".

(b) INTERNAL REVENUE CODE.—Section 9833 of the Internal Revenue Code of 1986 is amended—

(1) by striking "The Secretary" and inserting the following:

"(a) IN GENERAL.—The Secretary"; and

(2) by adding at the end the following:

"(b) MODIFICATION RELATING TO THE ELIMINATION OF THE INDIVIDUAL MARKETS.—

"(1) IN GENERAL.—The Secretary shall promulgate regulations, or modify existing regulations, under this chapter as the Secretary determines necessary to reflect changes in State law pursuant to the Ten Steps to Transform Health Care in America Act (and the amendments made by that Act) with respect to the treatment of individual State health insurance markets and to ensure the continued application of this part to self-funded group health plans notwithstanding such changes.

"(2) CLARIFICATIONS.—The regulations or modification promulgated under paragraph (1) shall not be construed as otherwise materially altering the provisions of this part as such provisions apply to self-funded group health plans. Nothing in this subsection shall be construed to preempt the application of State insurance laws with respect to State regulated health insurance products.".

SEC. 203. LEGISLATIVE PROPOSALS.

Not later than 1 year after the date of enactment of this Act, and every 3 years thereafter, the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary or the Treasury, in consultation with the National Association of Insurance Commissioners, shall jointly conduct a review of the effect of this subtitle (and the regulations promulgated thereunder) on health insurance access and affordability, particularly for individuals with chronic illness or catastrophic medical expenses, and on market competition, and shall submit a report concerning such review to the appropriate committees of Congress that contains proposals for such amendments as each such Secretary may determine would substantially improve the effectiveness and the implementation of this subtitle.

SEC. 204. ENFORCEMENT.

The provisions of section 106 shall apply with respect to the implementation and enforcement of the requirements of this subtitle in the same manner as such provisions apply to subtitle A of title I.

Subtitle B—Reduction in Premium Variation and Health Status Discrimination

SEC. 211. DEVELOPMENT OF STANDARDS FOR REDUCTION IN PREMIUM VARIATION AND HEALTH STATUS DISCRIMINATION AMONG ENROLLEES.

(a) IN GENERAL.—The Secretary, in consultation with State insurance commissioners and the National Association of Insurance Commissioners, shall promulgate regulations providing for the application by each State in the health insurance market of such State of improved standards regarding the range of allowable premium variation for enrollees.

(b) REQUIREMENTS.—The regulations promulgated under subsection (a) shall, with respect to each State, require—

(1) that for qualified core plans offered in the State—

(A) no premium variation based on health status or any other factor shall be permitted; and

(B) the standard premium amount shall be the same for all enrollees;

(2) that for compatible qualified core plans offered in the State—

(A) no premium variation based on health status shall be permitted; and

(B) rating variation based on enrollee age shall be the only permitted rating factor so long as the total variation in premium rates charged by an issuer for coverage under such plan shall not be greater than a factor of 2:1; and

(3) that for all other health insurance products offered in the State—

(A) no premium variation based on health status shall be permitted; and

(B) except as otherwise provided in this paragraph, premium variation shall be permitted as determined by State law, subject to the application of small group market rules to all insured health plan in a State pursuant to section 201(a) and (b).

(c) STATE RATING DISCRETION OTHERWISE PERMITTED.—Except as provided for in subsection (b), nothing in this section shall be construed to preempt the State application of such health insurance premium rating factors as a State may determine appropriate.

(d) STATE-BASED RISK ADJUSTMENTS.—

(1) IN GENERAL.—The regulations promulgated under subsection (a) and otherwise promulgated

under this subtitle shall require the State to establish risk adjustment requirements to reduce the effect of such material risk selection as may occur among qualified core plans, qualified core compatible plans, and other health plans in a State (not including self-insured plans) through the application of State risk adjustment requirements that are certified by the Secretary, pursuant to such regulations, as meeting standards established by the Secretary (in consultation with the National Association of Insurance Commissioners).

(2) ASSESSMENT AND REPORT ON STATE-BASED RISK ADJUSTMENT.—

(A) IN GENERAL.—Prior to the promulgation of standards under paragraph (1), the Secretary, in consultation with the National Association of Insurance Commissioners, shall conduct an assessment of—

(i) the degree of significant actual or actuarially anticipated material adverse selection among qualified core plans, qualified core compatible plans, and other insured health plans in a State; and

(ii) the comparative effectiveness of State risk adjustment requirement options

or mechanisms to reduce the effect of such adverse selection.

(B) REPORT.—The Secretary shall submit a report to Congress concerning the results of the assessment conducted under subparagraph (A). Such report may include recommendations by the Secretary for additional or future legislation to adjust the standards developed under paragraph (1) if the Secretary determines that such legislation is reasonably necessary to materially improve the effective application of State-based risk adjustment requirements pursuant to paragraph (1).

(e) STUDY AND REPORT ON PREMIUM RATING.—

(1) STUDY.—The Secretary, in consultation with the National Association of Insurance Commissioners, shall conduct ongoing reviews of the effect modification of State health insurance premium rating rules under this section will have, or has had, on health insurance affordability, access, and market competition in the insurance market in the States and on a national basis.

(2) REPORTS.—Not later than 1 year after the date of enactment of this Act, and every 2 years thereafter, the Secretary shall submit to the appro-

priate committees of Congress a report concerning the study conducted under paragraph (1), which may, as the Secretary may determine, include recommendations concerning proposed modifications and adjustments with respect to State premium rating rules.

SEC. 212. ENFORCEMENT.

The provisions of section 106 shall apply with respect to the implementation and enforcement of the requirements of this subtitle in the same manner as such provisions apply to subtitle A of title I.

Subtitle C—Enhanced Marketplace Pooling and Related Market Rating

PART I—ENHANCED MARKETPLACE POOLS

SEC. 245. RULES GOVERNING ENHANCED MARKETPLACE POOLS.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding after part 7 the following new part:

"PART 8—RULES GOVERNING ENHANCED MARKETPLACE POOLS

"SEC. 801. SMALL BUSINESS HEALTH PLANS.

"(a) IN GENERAL.—For purposes of this part, the term 'small business health plan' means a fully insured

group health plan whose sponsor is (or is deemed under this part to be) described in subsection (b).

"(b) SPONSORSHIP.—The sponsor of a group health plan is described in this subsection if such sponsor—

"(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a bona fide trade association, a bona fide industry association (including a rural electric cooperative association or a rural telephone cooperative association), a bona fide professional association, or a bona fide chamber of commerce (or similar bona fide business association, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining medical care;

"(2) is established as a permanent entity which receives the active support of its members and requires for membership payment on a periodic basis of dues or payments necessary to maintain eligibility for membership;

"(3) does not condition membership, such dues or payments, or coverage under the plan on the

basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation; and

"(4) does not condition membership on the basis of a minimum group size.

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1), (2), (3), and (4) shall be deemed to be a sponsor described in this subsection.

"SEC. 802. ALTERNATIVE MARKET POOLING ORGANIZATIONS.

"(a) IN GENERAL.—The Secretary, not later than 1 year after the date of enactment of this part, shall promulgate regulations that apply the rules and standards of this part, as necessary, to circumstances in which a pooling entity other (hereinafter 'Alternative Market Pooling Organizations') is not made up principally of employers and their employees, or not a professional organization or such small business health plan entity identified in section 801.

"(b) ADAPTION OF STANDARDS.—In developing and promulgating regulations pursuant to subsection (a), the Secretary, in consultation with the Secretary of Health and Human Services, small business health plans, small

and large employers, large and small insurance issuers, consumer representatives, and state insurance commissioners, shall—

"(1) adapt the standards of this part, to the maximum degree practicable, to assure balanced and comparable oversight standards for both small business health plans and alternative market pooling organizations;

"(2) permit the participation as alternative market pooling organizations unions, churches and other faith-based organizations, or other organizations composed of individuals and groups which may have little or no association with employment, provided however, that such alternative market pooling organizations meet, and continue meeting on an ongoing basis, to satisfy standards, rules, and requirements materially equivalent to those set forth in this part with respect to small business health plans;

"(3) conduct periodic verification of such compliance by alternative market pooling organizations, in consultation with the Secretary of Health and Human Services and the National Association of Insurance Commissioners, except that such periodic verification shall not materially impede market entry

or participation as pooling entities comparable to that of small business health plans; and

"(4) assure that consistent, clear, and regularly monitored standards are applied with respect to alternative market pooling organizations to avert material risk-selection within or among the composition of such organizations;

"(5) the expedited and deemed certification procedures provided in section 805(d) shall not apply to alternative market pooling organizations until sooner of the promulgation of regulations under this subsection or the expiration of one year following enactment of this Act; and

"(6) make such other appropriate adjustments to the requirements of this part as the Secretary may reasonably deem appropriate to fit the circumstances of an individual alternative market pooling organization or category of such organization, including but not limited to the application of the membership payment requirements of section 801(b)(2) to alternative market pooling organizations composed primarily of church- or faith-based membership.

"SEC. 803. CERTIFICATION OF SMALL BUSINESS HEALTH PLANS.

"(a) IN GENERAL.—Not later than 6 months after the date of enactment of this part, the applicable authority shall prescribe by interim final rule a procedure under which the applicable authority shall certify small business health plans which apply for certification as meeting the requirements of this part.

"(b) REQUIREMENTS APPLICABLE TO CERTIFIED PLANS.—A small business health plan with respect to which certification under this part is in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

"(c) REQUIREMENTS FOR CONTINUED CERTIFICATION.—The applicable authority may provide by regulation for continued certification of small business health plans under this part. Such regulation shall provide for the revocation of a certification if the applicable authority finds that the small business health plan involved is failing to comply with the requirements of this part.

"(d) EXPEDITED AND DEEMED CERTIFICATION.—

"(1) IN GENERAL.—If the Secretary fails to act on an application for certification under this section within 90 days of receipt of such application, the applying small business health plan shall be deemed

certified until such time as the Secretary may deny for cause the application for certification.

"(2) CIVIL PENALTY.—The Secretary may assess a civil penalty against the board of trustees and plan sponsor (jointly and severally) of a small business health plan that is deemed certified under paragraph (1) of up to $500,000 in the event the Secretary determines that the application for certification of such small business health plan was willfully or with gross negligence incomplete or inaccurate.

"SEC. 804. REQUIREMENTS RELATING TO SPONSORS AND BOARDS OF TRUSTEES.

"(a) SPONSOR.—The requirements of this subsection are met with respect to a small business health plan if the sponsor has met (or is deemed under this part to have met) the requirements of section 801(b) for a continuous period of not less than 3 years ending with the date of the application for certification under this part.

"(b) BOARD OF TRUSTEES.—The requirements of this subsection are met with respect to a small business health plan if the following requirements are met:

"(1) FISCAL CONTROL.—The plan is operated, pursuant to a plan document, by a board of trustees which pursuant to a trust agreement has complete

fiscal control over the plan and which is responsible for all operations of the plan.

"(2) RULES OF OPERATION AND FINANCIAL CONTROLS.—The board of trustees has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the plan and to meet all requirements of this title applicable to the plan.

"(3) RULES GOVERNING RELATIONSHIP TO PARTICIPATING EMPLOYERS AND TO CONTRACTORS.—

"(A) BOARD MEMBERSHIP.—

"(i) IN GENERAL.—Except as provided in clauses (ii) and (iii), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

"(ii) LIMITATION.—

"(I) GENERAL RULE.—Except as provided in subclauses (II) and (III), no such member is an owner, officer, director, or employee of, or partner in,

a contract administrator or other service provider to the plan.

"(II) LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON BEHALF OF THE SPONSOR.—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

"(III) TREATMENT OF PROVIDERS OF MEDICAL CARE.—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, subclause (I) shall not apply in the case of any service provider described in subclause (I) who is a provider of medical care under the plan.

"(iii) CERTAIN PLANS EXCLUDED.—Clause (i) shall not apply to a small business health plan which is in existence on

the date of the enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2007.

"(B) SOLE AUTHORITY.—The board has sole authority under the plan to approve applications for participation in the plan and to contract with insurers.

"(c) TREATMENT OF FRANCHISES.—In the case of a group health plan which is established and maintained by a franchiser for a franchisor or for its franchisees—

"(1) the requirements of subsection (a) and section 801(a) shall be deemed met if such requirements would otherwise be met if the franchisor were deemed to be the sponsor referred to in section 801(b) and each franchisee were deemed to be a member (of the sponsor) referred to in section 801(b); and

"(2) the requirements of section 804(a)(1) shall be deemed met.

For purposes of this subsection the terms 'franchisor' and 'franchisee' shall have the meanings given such terms for purposes of sections 436.2(a) through 436.2(c) of title 16, Code of Federal Regulations (including any such amendments to such regulation after the date of enactment of this part).

"SEC. 805. PARTICIPATION AND COVERAGE REQUIREMENTS.

"(a) COVERED EMPLOYERS AND INDIVIDUALS.—The requirements of this subsection are met with respect to a small business health plan if, under the terms of the plan—

"(1) each participating employer must be—

"(A) a member of the sponsor;

"(B) the sponsor; or

"(C) an affiliated member of the sponsor, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or such an affiliated member of the sponsor, participating employers may also include such employer; and

"(2) all individuals commencing coverage under the plan after certification under this part must be—

"(A) active or retired owners (including self-employed individuals), officers, directors, or employees of, or partners in, participating employers; or

"(B) the dependents of individuals described in subparagraph (A).

"(b) INDIVIDUAL MARKET UNAFFECTED.—The requirements of this subsection are met with respect to a small business health plan if, under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any employee not covered under the plan which is similar to the coverage contemporaneously provided to employees of the employer under the plan, if such exclusion of the employee from coverage under the plan is based on a health status-related factor with respect to the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the plan.

"(c) PROHIBITION OF DISCRIMINATION AGAINST EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.—The requirements of this subsection are met with respect to a small business health plan if—

"(1) under the terms of the plan, all employers meeting the preceding requirements of this section are eligible to qualify as participating employers for all geographically available coverage options, unless, in the case of any such employer, participation or contribution requirements of the type referred to in

section 2711 of the Public Health Service Act are not met;

"(2) information regarding all coverage options available under the plan is made readily available to any employer eligible to participate; and

"(3) the applicable requirements of sections 701, 702, and 703 are met with respect to the plan.

"SEC. 806. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS.

"(a) IN GENERAL.—The requirements of this section are met with respect to a small business health plan if the following requirements are met:

"(1) CONTENTS OF GOVERNING INSTRUMENTS.—

"(A) IN GENERAL.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

"(i) provides that the board of trustees serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A)); and

"(ii) provides that the sponsor of the plan is to serve as plan sponsor (referred to in section 3(16)(B)).

"(B) DESCRIPTION OF MATERIAL PROVISIONS.—The terms of the health insurance coverage (including the terms of any individual certificates that may be offered to individuals in connection with such coverage) describe the material benefit and rating, and other provisions set forth in this section and such material provisions are included in the summary plan description.

"(2) CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.—

"(A) IN GENERAL.—The contribution rates for any participating small employer shall not vary on the basis of any health status-related factor in relation to employees of such employer or their beneficiaries and shall not vary on the basis of the type of business or industry in which such employer is engaged, subject to subparagraph (B) and the terms of this title.

"(B) EFFECT OF TITLE.—Nothing in this title or any other provision of law shall be construed to preclude a health insurance issuer of-

fering health insurance coverage in connection with a small business health plan that meets the requirements of this part, and at the request of such small business health plan, from—

"(i) setting contribution rates for the small business health plan based on the claims experience of the small business health plan so long as any variation in such rates for participating small employers complies with the requirements of clause (ii), except that small business health plans shall not be subject, in non-adopting states, to subparagraphs (A)(ii) and (C) of section 2912(a)(2) of the Public Health Service Act, and in adopting states, to any State law that would have the effect of imposing requirements as outlined in such subparagraphs (A)(ii) and (C); or

"(ii) varying contribution rates for participating small employers in a small business health plan in a State to the extent that such rates could vary using the same methodology employed in such State for regulating small group premium rates,

subject to the terms of part I of subtitle A of title XXIX of the Public Health Service Act (relating to rating requirements), as added by title II of the Health Insurance Marketplace Modernization and Affordability Act of 2007.

"(3) EXCEPTIONS REGARDING SELF-EMPLOYED AND LARGE EMPLOYERS.—

"(A) SELF EMPLOYED.—

"(i) IN GENERAL.—Small business health plans with participating employers who are self-employed individuals (and their dependents) shall enroll such self-employed participating employers in accordance with rating rules that do not violate the rating rules for self-employed individuals in the State in which such self-employed participating employers are located.

"(ii) GUARANTEE ISSUE.—Small business health plans with participating employers who are self-employed individuals (and their dependents) may decline to guarantee issue to such participating employers in States in which guarantee issue

is not otherwise required for the self-employed in that State.

"(B) LARGE EMPLOYERS.—Small business health plans with participating employers that are larger than small employers (as defined in section 808(a)(10)) shall enroll such large participating employers in accordance with rating rules that do not violate the rating rules for large employers in the State in which such large participating employers are located.

"(4) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority determines are necessary to carry out the purposes of this part, which shall be prescribed by the applicable authority by regulation.

"(b) ABILITY OF SMALL BUSINESS HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude a small business health plan or a health insurance issuer offering health insurance coverage in connection with a small business health plan from exercising its sole discretion in selecting the specific benefits and services consisting of medical care to be included as benefits under such plan or coverage, except that such benefits and services must meet the terms

and specifications of part II of subtitle A of title XXIX of the Public Health Service Act (relating to lower cost plans), as added by title II of the Health Insurance Marketplace Modernization and Affordability Act of 2007.

"(c) DOMICILE AND NON-DOMICILE STATES.—

"(1) DOMICILE STATE.—Coverage shall be issued to a small business health plan in the State in which the sponsor's principal place of business is located.

"(2) NON-DOMICILE STATES.—With respect to a State (other than the domicile State) in which participating employers of a small business health plan are located but in which the insurer of the small business health plan in the domicile State is not yet licensed, the following shall apply:

"(A) TEMPORARY PREEMPTION.—If, upon the expiration of the 90-day period following the submission of a licensure application by such insurer (that includes a certified copy of an approved licensure application as submitted by such insurer in the domicile State) to such State, such State has not approved or denied such application, such State's health insurance licensure laws shall be temporarily preempted

and the insurer shall be permitted to operate in such State, subject to the following terms:

"(i) APPLICATION OF NON-DOMICILE STATE LAW.—Except with respect to licensure and with respect to the terms of subtitle A of title XXIX of the Public Health Service Act (relating to rating and benefits as added by the Health Insurance Marketplace Modernization and Affordability Act of 2007), the laws and authority of the non-domicile State shall remain in full force and effect.

"(ii) REVOCATION OF PREEMPTION.—The preemption of a non-domicile State's health insurance licensure laws pursuant to this subparagraph, shall be terminated upon the occurrence of either of the following:

"(I) APPROVAL OR DENIAL OF APPLICATION.—The approval of denial of an insurer's licensure application, following the laws and regulations of the non-domicile State with respect to licensure.

"(II) DETERMINATION OF MATERIAL VIOLATION.—A determination by a non-domicile State that an insurer operating in a non-domicile State pursuant to the preemption provided for in this subparagraph is in material violation of the insurance laws (other than licensure and with respect to the terms of subtitle A of title XXIX of the Public Health Service Act (relating to rating and benefits added by the Health Insurance Marketplace Modernization and Affordability Act of 2007)) of such State.

"(B) NO PROHIBITION ON PROMOTION.—Nothing in this paragraph shall be construed to prohibit a small business health plan or an insurer from promoting coverage prior to the expiration of the 90-day period provided for in subparagraph (A), except that no enrollment or collection of contributions shall occur before the expiration of such 90-day period.

"(C) LICENSURE.—Except with respect to the application of the temporary preemption provision of this paragraph, nothing in this part

shall be construed to limit the requirement that insurers issuing coverage to small business health plans shall be licensed in each State in which the small business health plans operate.

"(D) SERVICING BY LICENSED INSURERS.—Notwithstanding subparagraph (C), the requirements of this subsection may also be satisfied if the participating employers of a small business health plan are serviced by a licensed insurer in that State, even where such insurer is not the insurer of such small business health plan in the State in which such small business health plan is domiciled.

"SEC. 807. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

"(a) FILING FEE.—Under the procedure prescribed pursuant to section 802(a), a small business health plan shall pay to the applicable authority at the time of filing an application for certification under this part a filing fee in the amount of $5,000, which shall be available in the case of the Secretary, to the extent provided in appropriation Acts, for the sole purpose of administering the certification procedures applicable with respect to small business health plans.

"(b) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form which shall be prescribed by the applicable authority by regulation, at least the following information:

"(1) IDENTIFYING INFORMATION.—The names and addresses of—

"(A) the sponsor; and

"(B) the members of the board of trustees of the plan.

"(2) STATES IN WHICH PLAN INTENDS TO DO BUSINESS.—The States in which participants and beneficiaries under the plan are to be located and the number of them expected to be located in each such State.

"(3) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

"(4) PLAN DOCUMENTS.—A copy of the documents governing the plan (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits that will

be provided to participants and beneficiaries under the plan.

"(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the plan, health insurance issuer, and contract administrators and other service providers.

"(c) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted under this part to a small business health plan shall not be effective unless written notice of such certification is filed with the applicable State authority of each State in which the small business health plans operate.

"(d) NOTICE OF MATERIAL CHANGES.—In the case of any small business health plan certified under this part, descriptions of material changes in any information which was required to be submitted with the application for the certification under this part shall be filed in such form and manner as shall be prescribed by the applicable authority by regulation. The applicable authority may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

"SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

"A small business health plan which is or has been certified under this part may terminate (upon or at any time after cessation of accruals in benefit liabilities) only if the board of trustees, not less than 60 days before the proposed termination date—

"(1) provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date;

"(2) develops a plan for winding up the affairs of the plan in connection with such termination in a manner which will result in timely payment of all benefits for which the plan is obligated; and

"(3) submits such plan in writing to the applicable authority.

Actions required under this section shall be taken in such form and manner as may be prescribed by the applicable authority by regulation.

"SEC. 809. IMPLEMENTATION AND APPLICATION AUTHORITY BY SECRETARY.

"The Secretary shall, through promulgation and implementation of such regulations as the Secretary may reasonably determine necessary or appropriate, and in consultation with a balanced spectrum of effected entities

and persons, modify the implementation and application of this part to accommodate with minimum disruption such changes to State or Federal law provided in this part and the Ten Steps to Transform Health Care in America Act (and the amendments made by such Act) or in regulations issued thereto.

"SEC. 810. DEFINITIONS AND RULES OF CONSTRUCTION.

"(a) DEFINITIONS.—For purposes of this part—

"(1) AFFILIATED MEMBER.—The term 'affiliated member' means, in connection with a sponsor—

"(A) a person who is otherwise eligible to be a member of the sponsor but who elects an affiliated status with the sponsor, or

"(B) in the case of a sponsor with members which consist of associations, a person who is a member or employee of any such association and elects an affiliated status with the sponsor.

"(2) APPLICABLE AUTHORITY.—The term 'applicable authority' means the Secretary of Labor, except that, in connection with any exercise of the Secretary's authority with respect to which the Secretary is required under section 506(d) to consult with a State, such term means the Secretary, in consultation with such State.

"(3) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

"(4) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided in section 733(a)(1) (after applying subsection (b) of this section).

"(5) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided in section 733(b)(1), except that such term shall not include excepted benefits (as defined in section 733(c)).

"(6) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided in section 733(b)(2).

"(7) INDIVIDUAL MARKET.—

"(A) IN GENERAL.—The term 'individual market' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

"(B) TREATMENT OF VERY SMALL GROUPS.—

"(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

"(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

"(8) MEDICAL CARE.—The term 'medical care' has the meaning provided in section 733(a)(2).

"(9) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with a small business health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed indi-

vidual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

"(10) SMALL EMPLOYER.—The term 'small employer' means, in connection with a group health plan with respect to a plan year, a small employer as defined in section 2791(e)(4).

"(11) TRADE ASSOCIATION AND PROFESSIONAL ASSOCIATION.—The terms 'trade association' and 'professional association' mean an entity that meets the requirements of section 1.501(c)(6)–1 of title 26, Code of Federal Regulations (as in effect on the date of enactment of this Act).

"(b) RULE OF CONSTRUCTION.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is a small business health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

"(1) in the case of a partnership, the term 'employer' (as defined in section 3(5)) includes the partnership in relation to the partners, and the term

'employee' (as defined in section 3(6)) includes any partner in relation to the partnership; and

"(2) in the case of a self-employed individual, the term 'employer' (as defined in section 3(5)) and the term 'employee' (as defined in section 3(6)) shall include such individual.

"(c) RENEWAL.—Notwithstanding any provision of law to the contrary, a participating employer in a small business health plan shall not be deemed to be a plan sponsor in applying requirements relating to coverage renewal.

"(d) HEALTH SAVINGS ACCOUNTS.—Nothing in this part shall be construed to create any mandates for coverage of benefits for HSA-qualified health plans that would require reimbursements in violation of section 223(c)(2) of the Internal Revenue Code of 1986.".

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

(1) Section 514(b)(6) of such Act (29 U.S.C. 1144(b)(6)) is amended by adding at the end the following new subparagraph:

"(E) The preceding subparagraphs of this paragraph do not apply with respect to any State law in the case of a small business health plan which is certified under part 8.".

(2) Section 514 of such Act (29 U.S.C. 1144) is amended—

(A) in subsection (b)(4), by striking "Subsection (a)" and inserting "Subsections (a) and (d)";

(B) in subsection (b)(5), by striking "subsection (a)" in subparagraph (A) and inserting "subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805", and by striking "subsection (a)" in subparagraph (B) and inserting "subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805";

(C) by redesignating subsection (d) as subsection (e); and

(D) by inserting after subsection (c) the following new subsection:

"(d)(1) Except as provided in subsection (b)(4), the provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude a health insurance issuer from offering health insurance coverage in connection with a small business health plan which is certified under part 8.

"(2) In any case in which health insurance coverage of any policy type is offered under a small business health plan certified under part 8 to a participating employer op-

erating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may establish rating and benefit requirements that would otherwise apply to such coverage, provided the requirements of subtitle A of title XXIX of the Public Health Service Act (as added by title II of the Health Insurance Marketplace Modernization and Affordability Act of 2007) (concerning health plan rating and benefits) are met.".

(c) PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 102(16)(B)) is amended by adding at the end the following new sentence: "Such term also includes a person serving as the sponsor of a small business health plan under part 8.".

(d) SAVINGS CLAUSE.—Section 731(c) of such Act is amended by inserting "or part 8" after "this part".

(e) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 734 the following new items:

"PART 8—RULES GOVERNING SMALL BUSINESS HEALTH PLANS

"801. Small business health plans.
"802. Alternative market pooling organizations.
"803. Certification of small business health plans.
"804. Requirements relating to sponsors and boards of trustees.
"805. Participation and coverage requirements.
"806. Other requirements relating to plan documents, contribution rates, and benefit options.
"807. Requirements for application and related requirements.
"808. Notice requirements for voluntary termination.
"809. Implementation and application authority by Secretary.
"810. Definitions and rules of construction.".

SEC. 246. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

"(d) CONSULTATION WITH STATES WITH RESPECT TO SMALL BUSINESS HEALTH PLANS.—

"(1) AGREEMENTS WITH STATES.—The Secretary shall consult with the State recognized under paragraph (2) with respect to a small business health plan regarding the exercise of—

"(A) the Secretary's authority under sections 502 and 504 to enforce the requirements for certification under part 8; and

"(B) the Secretary's authority to certify small business health plans under part 8 in accordance with regulations of the Secretary applicable to certification under part 8.

"(2) RECOGNITION OF DOMICILE STATE.—In carrying out paragraph (1), the Secretary shall ensure that only one State will be recognized, with respect to any particular small business health plan, as the State with which consultation is required. In carrying out this paragraph such State shall be the domicile State, as defined in section 805(c).".

SEC. 247. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) EFFECTIVE DATE.—The amendments made by this subtitle shall take effect 12 months after the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this subtitle within 6 months after the date of the enactment of this Act.

(b) TREATMENT OF CERTAIN EXISTING HEALTH BENEFITS PROGRAMS.—

(1) IN GENERAL.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the purpose of providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make contributions to such arrangement, such arrangement has been in existence for at least 10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 808(a)(2) of the Employee Retirement Income Security Act of 1974 (as amended by this subtitle)) by the arrangement of an application for certification of the ar-

rangement under part 8 of subtitle B of title I of such Act—

(A) such arrangement shall be deemed to be a group health plan for purposes of title I of such Act;

(B) the requirements of sections 801(a) and 803(a) of the Employee Retirement Income Security Act of 1974 shall be deemed met with respect to such arrangement;

(C) the requirements of section 803(b) of such Act shall be deemed met, if the arrangement is operated by a board of trustees which has control over the arrangement;

(D) the requirements of section 804(a) of such Act shall be deemed met with respect to such arrangement; and

(E) the arrangement may be certified by any applicable authority with respect to its operations in any State only if it operates in such State on the date of certification.

The provisions of this subsection shall cease to apply with respect to any such arrangement at such time after the date of the enactment of this Act as the applicable requirements of this subsection are not met with respect to such arrangement or at such

time that the arrangement provides coverage to participants and beneficiaries in any State other than the States in which coverage is provided on such date of enactment.

(2) DEFINITIONS.—For purposes of this subsection, the terms "group health plan", "medical care", and "participating employer" shall have the meanings provided in section 808 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an "small business health plan" shall be deemed a reference to an arrangement referred to in this subsection.

PART II—MARKET RELIEF

SEC. 251. MARKET RELIEF.

The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

"TITLE XXIX—HEALTH CARE INSURANCE MARKETPLACE MODERNIZATION

"SEC. 2901. GENERAL INSURANCE DEFINITIONS.

"In this title, the terms 'health insurance coverage', 'health insurance issuer', 'group health plan', and 'individual health insurance' shall have the meanings given such terms in section 2791.

"SEC. 2902. IMPLEMENTATION AND APPLICATION AUTHORITY BY SECRETARY.

"The Secretary shall, through promulgation and implementation of such regulations as the Secretary may reasonably determine necessary or appropriate, and in consultation with a balanced spectrum of effected entities and persons, modify the implementation and application of this title to accommodate with minimum disruption such changes to State or Federal law provided in this title and the Ten Steps to Transform Health Care in America Act (and the amendments made by such Act) or in regulations issued thereto.

"Subtitle A—Market Relief

"PART I—RATING REQUIREMENTS

"SEC. 2911. DEFINITIONS.

"In this part:

"(1) ADOPTING STATE.—The term 'adopting State' means a State that, with respect to the small group market, has enacted small group rating rules that meet the minimum standards set forth in section 2912(a)(1) or, as applicable, transitional small group rating rules set forth in section 2912(b).

"(2) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials des-

ignated by the State to enforce the insurance laws of such State.

"(3) BASE PREMIUM RATE.—The term 'base premium rate' means, for each class of business with respect to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage

"(4) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a State and that—

"(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage consistent with the Model Small Group Rating Rules or, as applicable, transitional small group rating rules in a State;

"(B) notifies the insurance department of a nonadopting State (or other State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer small group health

insurance coverage in that State consistent with the Model Small Group Rating Rules, and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency); and

"(C) includes in the terms of the health insurance coverage offered in nonadopting States (including in the terms of any individual certificates that may be offered to individuals in connection with such group health coverage) and filed with the State pursuant to subparagraph (B), a description in the insurer's contract of the Model Small Group Rating Rules and an affirmation that such Rules are included in the terms of such contract.

"(5) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the small group health insurance market, except that such term shall not include excepted benefits (as defined in section 2791(c)).

"(6) INDEX RATE.—The term 'index rate' means for each class of business with respect to the

rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

"(7) MODEL SMALL GROUP RATING RULES.—The term ' Model Small Group Rating Rules' means the rules set forth in section 2912(a)(2).

"(8) NONADOPTING STATE.—The term 'nonadopting State' means a State that is not an adopting State.

"(9) SMALL GROUP INSURANCE MARKET.—The term 'small group insurance market' shall have the meaning given the term 'small group market' in section 2791(e)(5).

"(10) STATE LAW.—The term 'State law' means all laws, decisions, rules, regulations, or other State actions (including actions by a State agency) having the effect of law, of any State.

"(11) VARIATION LIMITS.—

"(A) COMPOSITE VARIATION LIMIT.—

"(i) IN GENERAL.—The term 'composite variation limit' means the total variation in premium rates charged by a health insurance issuer in the small group market as permitted under applicable State

law based on the following factors or case characteristics:

"(I) Age.

"(II) Duration of coverage.

"(III) Claims experience.

"(IV) Health status.

"(ii) USE OF FACTORS.—With respect to the use of the factors described in clause (i) in setting premium rates, a health insurance issuer shall use one or both of the factors described in subclauses (I) or (IV) of such clause and may use the factors described in subclauses (II) or (III) of such clause.

"(B) TOTAL VARIATION LIMIT.—The term 'total variation limit' means the total variation in premium rates charged by a health insurance issuer in the small group market as permitted under applicable State law based on all factors and case characteristics (as described in section 2912(a)(1)).

"SEC. 2912. RATING RULES.

"(a) ESTABLISHMENT OF MINIMUM STANDARDS FOR PREMIUM VARIATIONS AND MODEL SMALL GROUP RATING RULES.—Not later than 6 months after the date of

enactment of this title, the Secretary shall promulgate regulations establishing the following Minimum Standards and Model Small Group Rating Rules:

"(1) MINIMUM STANDARDS FOR PREMIUM VARIATIONS.—

"(A) COMPOSITE VARIATION LIMIT.—The composite variation limit shall not be less than 3:1.

"(B) TOTAL VARIATION LIMIT.—The total variation limit shall not be less than 5:1.

"(C) PROHIBITION ON USE OF CERTAIN CASE CHARACTERISTICS.—For purposes of this paragraph, in calculating the total variation limit, the State shall not use case characteristics other than those used in calculating the composite variation limit and industry, geographic area, group size, participation rate, class of business, and participation in wellness programs.

"(2) MODEL SMALL GROUP RATING RULES.—The following apply to an eligible insurer in a nonadopting State:

"(A) PREMIUM RATES.—Premium rates for small group health benefit plans to which this title applies shall comply with the following

provisions relating to premiums, except as provided for under subsection (b):

"(i) VARIATION IN PREMIUM RATES.—The plan may not vary premium rates by more than the minimum standards provided for under paragraph (1).

"(ii) INDEX RATE.—The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than 20 percent, excluding those classes of business related to association groups under this title.

"(iii) CLASS OF BUSINESSES.—With respect to a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage or the rates that could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than 25 percent of the index rate under clause (ii).

"(iv) INCREASES FOR NEW RATING PERIODS.—The percentage increase in the

premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

"(I) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, except that such change shall not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

"(II) Any adjustment, not to exceed 15 percent annually and adjusted pro rata for rating periods of less then 1 year, due to the claim experience, health status or duration of cov-

erage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business involved.

"(III) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

"(v) UNIFORM APPLICATION OF ADJUSTMENTS.—Adjustments in premium rates for claim experience, health status, or duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

"(vi) PROHIBITION ON USE OF CERTAIN CASE CHARACTERISTIC.—A small employer carrier shall not utilize case characteristics, other than those permitted under paragraph (1)(C), without the prior approval of the applicable State authority.

"(vii) CONSISTENT APPLICATION OF FACTORS.—Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

"(viii) TREATMENT OF PLANS AS HAVING SAME RATING PERIOD.—A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

"(ix) REQUIRE COMPLIANCE.—Premium rates for small business health benefit plans shall comply with the requirements of this subsection notwithstanding any assessments paid or payable by a small employer carrier as required by a State's small employer carrier reinsurance program.

"(B) ESTABLISHMENT OF SEPARATE CLASS OF BUSINESS.—Subject to subparagraph (C), a small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following:

"(i) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers.

"(ii) The small employer carrier has acquired a class of business from another small employer carrier.

"(iii) The small employer carrier provides coverage to one or more association groups that meet the requirements of this title.

"(C) LIMITATION.—A small employer carrier may establish up to 9 separate classes of business under subparagraph (B), excluding those classes of business related to association groups under this title.

"(D) LIMITATION ON TRANSFERS.—A small employer carrier shall not transfer a

small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage since issue.

"(b) TRANSITIONAL MODEL SMALL GROUP RATING RULES.—

"(1) IN GENERAL.—Not later than 6 months after the date of enactment of this title and to the extent necessary to provide for a graduated transition to the minimum standards for premium variation as provided for in subsection (a)(1), the Secretary, in consultation with the National Association of Insurance Commissioners (NAIC), shall promulgate State-specific transitional small group rating rules in accordance with this subsection, which shall be applicable with respect to non-adopting States and eligible insurers operating in such States for a period of not to exceed 3 years from the date of the promulgation of the minimum standards for premium variation pursuant to subsection (a).

"(2) COMPLIANCE WITH TRANSITIONAL MODEL SMALL GROUP RATING RULES.—During the transition period described in paragraph (1), a State that, on the date of enactment of this title, has in effect a small group rating rules methodology that allows for a variation that is less than the variation provided for under subsection (a)(1) (concerning minimum standards for premium variation), shall be deemed to be an adopting State if the State complies with the transitional small group rating rules as promulgated by the Secretary pursuant to paragraph (1).

"(3) TRANSITIONING OF OLD BUSINESS.—

"(A) IN GENERAL.—In developing the transitional small group rating rules under paragraph (1), the Secretary shall, after consultation with the National Association of Insurance Commissioners and representatives of insurers operating in the small group health insurance market in non-adopting States, promulgate special transition standards with respect to independent rating classes for old and new business, to the extent reasonably necessary to protect health insurance consumers and to ensure

a stable and fair transition for old and new market entrants.

"(B) PERIOD FOR OPERATION OF INDEPENDENT RATING CLASSES.—In developing the special transition standards pursuant to subparagraph (A), the Secretary shall permit a carrier in a non-adopting State, at its option, to maintain independent rating classes for old and new business for a period of up to 5 years, with the commencement of such 5-year period to begin at such time, but not later than the date that is 3 years after the date of enactment of this title, as the carrier offers a book of business meeting the minimum standards for premium variation provided for in subsection (a)(1) or the transitional small group rating rules under paragraph (1).

"(4) OTHER TRANSITIONAL AUTHORITY.—In developing the transitional small group rating rules under paragraph (1), the Secretary shall provide for the application of the transitional small group rating rules in transition States as the Secretary may determine necessary for a an effective transition.

"(e) MARKET RE-ENTRY.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, a health insurance issuer that has voluntarily withdrawn from providing coverage in the small group market prior to the date of enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2007 shall not be excluded from re-entering such market on a date that is more than 180 days after such date of enactment.

"(2) TERMINATION.—The provision of this subsection shall terminate on the date that is 24 months after the date of enactment of the Health Insurance Marketplace Modernization and Affordability Act of 2007.

"SEC. 2913. APPLICATION AND PREEMPTION.

"(a) SUPERSEDING OF STATE LAW.—

"(1) IN GENERAL.—This part shall supersede any and all State laws of a non-adopting State insofar as such State laws (whether enacted prior to or after the date of enactment of this subtitle) relate to rating in the small group insurance market as applied to an eligible insurer, or small group health insurance coverage issued by an eligible insurer, including with respect to coverage issued to a small employer through a small business health plan, in a State.

"(2) NONADOPTING STATES.—This part shall supersede any and all State laws of a nonadopting State insofar as such State laws (whether enacted prior to or after the date of enactment of this subtitle)—

"(A) prohibit an eligible insurer from offering, marketing, or implementing small group health insurance coverage consistent with the Model Small Group Rating Rules or transitional model small group rating rules; or

"(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing small group health insurance coverage consistent with the Model Small Group Rating Rules or transitional model small group rating rules.

"(b) SAVINGS CLAUSE AND CONSTRUCTION.—

"(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting states.

"(2) NONAPPLICATION TO CERTAIN INSURERS.—Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers that

offer small group health insurance coverage in a nonadopting State.

"(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not supercede any State law in a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the Model Small Group Rating Rules or transitional model small group rating rules.

"(4) NO EFFECT ON PREEMPTION.—In no case shall this part be construed to limit or affect in any manner the preemptive scope of sections 502 and 514 of the Employee Retirement Income Security Act of 1974. In no case shall this part be construed to create any cause of action under Federal or State law or enlarge or affect any remedy available under the Employee Retirement Income Security Act of 1974.

"(5) PREEMPTION LIMITED TO RATING.—Subsection (a) shall not preempt any State law that does not have a reference to or a connection with State rating rules that would otherwise apply to eligible insurers.

"(c) EFFECTIVE DATE.—This section shall apply, at the election of the eligible insurer, beginning in the first plan year or the first calendar year following the issuance of the final rules by the Secretary under the Model Small Group Rating Rules or, as applicable, the Transitional Model Small Group Rating Rules, but in no event earlier than the date that is 12 months after the date of enactment of this title.

"SEC. 2914. CIVIL ACTIONS AND JURISDICTION.

"(a) IN GENERAL.—The courts of the United States shall have exclusive jurisdiction over civil actions involving the interpretation of this part.

"(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 2913.

"(c) DIRECT FILING IN COURT OF APPEALS.—At the election of the eligible insurer, an action may be brought under subsection (b) directly in the United States Court of Appeals for the circuit in which the nonadopting State is located by the filing of a petition for review in such Court.

"(d) EXPEDITED REVIEW.—

"(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

"(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

"(e) STANDARD OF REVIEW.—A court in an action filed under this section, shall render a judgment based on a review of the merits of all questions presented in such action and shall not defer to any conduct or action, or proposed conduct or action, of a nonadopting State.

"SEC. 2915. ONGOING REVIEW.

"Not later than 5 years after the date on which the Model Small Group Rating Rules are issued under this part, and every 5 years thereafter, the Secretary, in consultation with the National Association of Insurance Commissioners, shall prepare and submit to the appropriate committees of Congress a report that assesses the effect of the Model Small Group Rating Rules on access, cost, and market functioning in the small group market. Such report may, if the Secretary, in consultation with the National Association of Insurance Commissioners, determines such is appropriate for improving access, costs, and market functioning, contain legislative proposals for recommended modification to such Model Small Group Rating Rules.

"PART II—AFFORDABLE PLANS

"SEC. 2921. DEFINITIONS.

"In this part:

"(1) ADOPTING STATE.—The term 'adopting State' means a State that has enacted a law providing that small group, individual, and large group health insurers in such State may offer and sell products in accordance with the List of Required Benefits and the Terms of Application as provided for in section 2922(b)

"(2) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a nonadopting State and that—

"(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage consistent with the List of Required Benefits and Terms of Application in a nonadopting State;

"(B) notifies the insurance department of a nonadopting State (or other applicable State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage in that State consistent with the List of Required Benefits and Terms of Application, and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency) by the Secretary in regulations; and

"(C) includes in the terms of the health insurance coverage offered in nonadopting States

(including in the terms of any individual certificates that may be offered to individuals in connection with such group health coverage) and filed with the State pursuant to subparagraph (B), a description in the insurer's contract of the List of Required Benefits and a description of the Terms of Application, including a description of the benefits to be provided, and that adherence to such standards is included as a term of such contract.

"(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the small group, individual, or large group health insurance markets, including with respect to small business health plans, except that such term shall not include excepted benefits (as defined in section 2791(c)).

"(4) LIST OF REQUIRED BENEFITS.—The term 'List of Required Benefits' means the List issued under section 2922(a).

"(5) NONADOPTING STATE.—The term 'nonadopting State' means a State that is not an adopting State.

"(6) STATE LAW.—The term 'State law' means all laws, decisions, rules, regulations, or other State

actions (including actions by a State agency) having the effect of law, of any State.

"(7) STATE PROVIDER FREEDOM OF CHOICE LAW.—The term 'State Provider Freedom of Choice Law' means a State law requiring that a health insurance issuer, with respect to health insurance coverage, not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law.

"(8) TERMS OF APPLICATION.—The term 'Terms of Application' means terms provided under section 2922(a).

"SEC. 2922. OFFERING AFFORDABLE PLANS.

"(a) LIST OF REQUIRED BENEFITS.—Not later than 3 months after the date of enactment of this title, the Secretary, in consultation with the National Association of Insurance Commissioners, shall issue by interim final rule a list (to be known as the 'List of Required Benefits') of covered benefits, services, or categories of providers that are required to be provided by health insurance issuers, in each of the small group, individual, and large group markets, in at least 26 States as a result of the application of State covered benefit, service, and category of provider mandate laws. With respect to plans sold to or through

small business health plans, the List of Required Benefits applicable to the small group market shall apply.

"(b) TERMS OF APPLICATION.—

"(1) STATE WITH MANDATES.—With respect to a State that has a covered benefit, service, or category of provider mandate in effect that is covered under the List of Required Benefits under subsection (a), such State mandate shall, subject to paragraph (3) (concerning uniform application), apply to a coverage plan or plan in, as applicable, the small group, individual, or large group market or through a small business health plan in such State.

"(2) STATES WITHOUT MANDATES.—With respect to a State that does not have a covered benefit, service, or category of provider mandate in effect that is covered under the List of Required Benefits under subsection (a), such mandate shall not apply, as applicable, to a coverage plan or plan in the small group, individual, or large group market or through a small business health plan in such State.

"(3) UNIFORM APPLICATION OF LAWS.—

"(A) IN GENERAL.—With respect to a State described in paragraph (1), in applying a covered benefit, service, or category of provider mandate that is on the List of Required Bene-

fits under subsection (a) the State shall permit a coverage plan or plan offered in the small group, individual, or large group market or through a small business health plan in such State to apply such benefit, service, or category of provider coverage in a manner consistent with the manner in which such coverage is applied under one of the three most heavily subscribed national health plans offered under the Federal Employee Health Benefits Program under chapter 89 of title 5, United States Code (as determined by the Secretary in consultation with the Director of the Office of Personnel Management), and consistent with the Publication of Benefit Applications under subsection (c). In the event a covered benefit, service, or category of provider appearing in the List of Required Benefits is not offered in one of the three most heavily subscribed national health plans offered under the Federal Employees Health Benefits Program, such covered benefit, service, or category of provider requirement shall be applied in a manner consistent with the manner in which such coverage is offered in the remaining most heavily subscribed plan of the

remaining Federal Employees Health Benefits Program plans, as determined by the Secretary, in consultation with the Director of the Office of Personnel Management.

"(B) EXCEPTION REGARDING STATE PROVIDER FREEDOM OF CHOICE LAWS.—Notwithstanding subparagraph (A), in the event a category of provider mandate is included in the List of Covered Benefits, any State Provider Freedom of Choice Law (as defined in section 2921(7)) that is in effect in any State in which such category of provider mandate is in effect shall not be preempted, with respect to that category of provider, by this part.

"(c) PUBLICATION OF BENEFIT APPLICATIONS.—Not later than 3 months after the date of enactment of this title, and on the first day of every calendar year thereafter, the Secretary, in consultation with the Director of the Office of Personnel Management, shall publish in the Federal Register a description of such covered benefits, services, and categories of providers covered in that calendar year by each of the three most heavily subscribed nationally available Federal Employee Health Benefits Plan options which are also included on the List of Required Benefits.

"(d) EFFECTIVE DATES.—

"(1) SMALL BUSINESS HEALTH PLANS.—With respect to health insurance provided to participating employers of small business health plans, the requirements of this part (concerning lower cost plans) shall apply beginning on the date that is 12 months after the date of enactment of this title.

"(2) NON-ASSOCIATION COVERAGE.—With respect to health insurance provided to groups or individuals other than participating employers of small business health plans, the requirements of this part shall apply beginning on the date that is 15 months after the date of enactment of this title.

"(e) UPDATING OF LIST OF REQUIRED BENEFITS.—Not later than 2 years after the date on which the list of required benefits is issued under subsection (a), and every 2 years thereafter, the Secretary, in consultation with the National Association of Insurance Commissioners, shall update the list based on changes in the laws and regulations of the States. The Secretary shall issue the updated list by regulation, and such updated list shall be effective upon the first plan year following the issuance of such regulation.

"SEC. 2923. APPLICATION AND PREEMPTION.

"(a) SUPERCEDING OF STATE LAW.—

"(1) IN GENERAL.—This part shall supersede any and all State laws insofar as such laws relate to mandates relating to covered benefits, services, or categories of provider in the health insurance market as applied to an eligible insurer, or health insurance coverage issued by an eligible insurer, including with respect to coverage issued to a small business health plan, in a nonadopting State.

"(2) NONADOPTING STATES.—This part shall supersede any and all State laws of a nonadopting State (whether enacted prior to or after the date of enactment of this title) insofar as such laws—

"(A) prohibit an eligible insurer from offering, marketing, or implementing health insurance coverage consistent with the Benefit Choice Standards, as provided for in section 2922(a); or

"(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing health insurance coverage consistent with the Benefit Choice Standards.

"(b) SAVINGS CLAUSE AND CONSTRUCTION.—

"(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting States.

"(2) NONAPPLICATION TO CERTAIN INSURERS.—Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers who offer health insurance coverage in a nonadopting State.

"(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not supercede any State law of a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the Benefit Choice Standards.

"(4) NO EFFECT ON PREEMPTION.—In no case shall this part be construed to limit or affect in any manner the preemptive scope of sections 502 and 514 of the Employee Retirement Income Security Act of 1974. In no case shall this part be construed to create any cause of action under Federal or State law or enlarge or affect any remedy available under the Employee Retirement Income Security Act of 1974.

"(5) PREEMPTION LIMITED TO BENEFITS.—Subsection (a) shall not preempt any State law that does not have a reference to or a connection with State mandates regarding covered benefits, services, or categories of providers that would otherwise apply to eligible insurers.

"SEC. 2924. CIVIL ACTIONS AND JURISDICTION.

"(a) IN GENERAL.—The courts of the United States shall have exclusive jurisdiction over civil actions involving the interpretation of this part.

"(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 2923.

"(c) DIRECT FILING IN COURT OF APPEALS.—At the election of the eligible insurer, an action may be brought under subsection (b) directly in the United States Court of Appeals for the circuit in which the nonadopting State is located by the filing of a petition for review in such Court.

"(d) EXPEDITED REVIEW.—

"(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

"(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

"(e) STANDARD OF REVIEW.—A court in an action filed under this section, shall render a judgment based on a review of the merits of all questions presented in such action and shall not defer to any conduct or action, or proposed conduct or action, of a nonadopting State.

"SEC. 2925. RULES OF CONSTRUCTION.

"(a) IN GENERAL.—Notwithstanding any other provision of Federal or State law, a health insurance issuer in an adopting State or an eligible insurer in a non-adopting State may amend its existing policies to be consistent with the terms of this subtitle (concerning rating and benefits).

"(b) HEALTH SAVINGS ACCOUNTS.—Nothing in this subtitle shall be construed to create any mandates for coverage of benefits for HSA-qualified health plans that would require reimbursements in violation of section 223(c)(2) of the Internal Revenue Code of 1986.".

PART III—HARMONIZATION OF HEALTH INSURANCE STANDARDS

SEC. 261. HEALTH INSURANCE STANDARDS HARMONIZATION.

Title XXIX of the Public Health Service Act (as added by section 201) is amended by adding at the end the following:

"Subtitle B—Standards Harmonization

"SEC. 2931. DEFINITIONS.

"In this subtitle:

"(1) ADOPTING STATE.—The term 'adopting State' means a State that has enacted the harmonized standards adopted under this subtitle in

their entirety and as the exclusive laws of the State that relate to the harmonized standards.

"(2) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a nonadopting State and that—

"(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage consistent with the harmonized standards in a nonadopting State;

"(B) notifies the insurance department of a nonadopting State (or other State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage in that State consistent with the harmonized standards published pursuant to section 2933(d), and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency) by the Secretary in regulations; and

"(C) includes in the terms of the health insurance coverage offered in nonadopting States (including in the terms of any individual certificates that may be offered to individuals in connection with such health coverage) and filed with the State pursuant to subparagraph (B), a description of the harmonized standards published pursuant to section 2933(g)(2) and an affirmation that such standards are a term of the contract.

"(3) HARMONIZED STANDARDS.—The term 'harmonized standards' means the standards certified by the Secretary under section 2933(d).

"(4) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the health insurance market, except that such term shall not include excepted benefits (as defined in section 2791(c).

"(5) NONADOPTING STATE.—The term 'nonadopting State' means a State that fails to enact, within 18 months of the date on which the Secretary certifies the harmonized standards under this subtitle, the harmonized standards in their entirety and as the exclusive laws of the State that relate to the harmonized standards.

"(6) STATE LAW.—The term 'State law' means all laws, decisions, rules, regulations, or other State actions (including actions by a State agency) having the effect of law, of any State.

"SEC. 2932. HARMONIZED STANDARDS.

"(a) BOARD.—

"(1) ESTABLISHMENT.—Not later than 3 months after the date of enactment of this title, the Secretary, in consultation with the NAIC, shall establish the Health Insurance Consensus Standards Board (referred to in this subtitle as the 'Board') to develop recommendations that harmonize inconsistent State health insurance laws in accordance with the procedures described in subsection (b).

"(2) COMPOSITION.—

"(A) IN GENERAL.—The Board shall be composed of the following voting members to be appointed by the Secretary after considering the recommendations of professional organizations representing the entities and constituencies described in this paragraph:

"(i) Four State insurance commissioners as recommended by the National Association of Insurance Commissioners, of which 2 shall be Democrats and 2 shall be

Republicans, and of which one shall be designated as the chairperson and one shall be designated as the vice chairperson.

"(ii) Four representatives of State government, two of which shall be governors of States and two of which shall be State legislators, and two of which shall be Democrats and two of which shall be Republicans.

"(iii) Four representatives of health insurers, of which one shall represent insurers that offer coverage in the small group market, one shall represent insurers that offer coverage in the large group market, one shall represent insurers that offer coverage in the individual market, and one shall represent carriers operating in a regional market.

"(iv) Two representatives of insurance agents and brokers.

"(v) Two independent representatives of the American Academy of Actuaries who have familiarity with the actuarial methods applicable to health insurance.

"(B) EX OFFICIO MEMBER.—A representative of the Secretary shall serve as an ex officio member of the Board.

"(3) ADVISORY PANEL.—The Secretary shall establish an advisory panel to provide advice to the Board, and shall appoint its members after considering the recommendations of professional organizations representing the entities and constituencies identified in this paragraph:

"(A) Two representatives of small business health plans.

"(B) Two representatives of employers, of which one shall represent small employers and one shall represent large employers.

"(C) Two representatives of consumer organizations.

"(D) Two representatives of health care providers.

"(4) QUALIFICATIONS.—The membership of the Board shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health plans, providers of health services, and other related fields, who provide a mix of different professionals, broad geographic

representation, and a balance between urban and rural representatives.

"(5) ETHICAL DISCLOSURE.—The Secretary shall establish a system for public disclosure by members of the Board of financial and other potential conflicts of interest relating to such members. Members of the Board shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

"(6) DIRECTOR AND STAFF.—Subject to such review as the Secretary deems necessary to assure the efficient administration of the Board, the chair and vice-chair of the Board may—

"(A) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

"(B) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

"(C) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Board (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

"(D) make advance, progress, and other payments which relate to the work of the Board;

"(E) provide transportation and subsistence for persons serving without compensation; and

"(F) prescribe such rules as it deems necessary with respect to the internal organization and operation of the Board.

"(7) TERMS.—The members of the Board shall serve for the duration of the Board. Vacancies in the Board shall be filled as needed in a manner consistent with the composition described in paragraph (2).

"(b) DEVELOPMENT OF HARMONIZED STANDARDS.—

"(1) IN GENERAL.—In accordance with the process described in subsection (c), the Board shall identify and recommend nationally harmonized

standards for each of the following process categories:

"(A) FORM FILING AND RATE FILING.—Form and rate filing standards shall be established which promote speed to market and include the following defined areas for States that require such filings:

"(i) Procedures for form and rate filing pursuant to a streamlined administrative filing process.

"(ii) Timeframes for filings to be reviewed by a State if review is required before they are deemed approved.

"(iii) Timeframes for an eligible insurer to respond to State requests following its review.

"(iv) A process for an eligible insurer to self-certify.

"(v) State development of form and rate filing templates that include only non-preempted State law and Federal law requirements for eligible insurers with timely updates.

"(vi) Procedures for the resubmission of forms and rates.

"(vii) Disapproval rationale of a form or rate filing based on material omissions or violations of non-preempted State law or Federal law with violations cited and explained.

"(viii) For States that may require a hearing, a rationale for hearings based on violations of non-preempted State law or insurer requests.

"(B) MARKET CONDUCT REVIEW.—Market conduct review standards shall be developed which provide for the following:

"(i) Mandatory participation in national databases.

"(ii) The confidentiality of examination materials.

"(iii) The identification of the State agency with primary responsibility for examinations.

"(iv) Consultation and verification of complaint data with the eligible insurer prior to State actions.

"(v) Consistency of reporting requirements with the recordkeeping and administrative practices of the eligible insurer.

"(vi) Examinations that seek to correct material errors and harmful business practices rather than infrequent errors.

"(vii) Transparency and publishing of the State's examination standards.

"(viii) Coordination of market conduct analysis.

"(ix) Coordination and nonduplication between State examinations of the same eligible insurer.

"(x) Rationale and protocols to be met before a full examination is conducted.

"(xi) Requirements on examiners prior to beginning examinations such as budget planning and work plans.

"(xii) Consideration of methods to limit examiners' fees such as caps, competitive bidding, or other alternatives.

"(xiii) Reasonable fines and penalties for material errors and harmful business practices.

"(C) PROMPT PAYMENT OF CLAIMS.—The Board shall establish prompt payment standards for eligible insurers based on standards similar to those applicable to the Social Secu-

rity Act as set forth in section 1842(c)(2) of such Act (42 U.S.C. 1395u(c)(2)). Such prompt payment standards shall be consistent with the timing and notice requirements of the claims procedure rules to be specified under subparagraph (D), and shall include appropriate exceptions such as for fraud, nonpayment of premiums, or late submission of claims.

"(D) INTERNAL REVIEW.—The Board shall establish standards for claims procedures for eligible insurers that are consistent with the requirements relating to initial claims for benefits and appeals of claims for benefits under the Employee Retirement Income Security Act of 1974 as set forth in section 503 of such Act (29 U.S.C. 1133) and the regulations thereunder.

"(2) RECOMMENDATIONS.—The Board shall recommend harmonized standards for each element of the categories described in subparagraph (A) through (D) of paragraph (1) within each such market. Notwithstanding the previous sentence, the Board shall not recommend any harmonized standards that disrupt, expand, or duplicate the benefit, service, or provider mandate standards provided in

the Benefit Choice Standards pursuant to section 2922(a).

"(c) PROCESS FOR IDENTIFYING HARMONIZED STANDARDS.—

"(1) IN GENERAL.—The Board shall develop recommendations to harmonize inconsistent State insurance laws with respect to each of the process categories described in subparagraphs (A) through (D) of subsection (b)(1).

"(2) REQUIREMENTS.—In adopting standards under this section, the Board shall consider the following:

"(A) Any model acts or regulations of the National Association of Insurance Commissioners in each of the process categories described in subparagraphs (A) through (D) of subsection (b)(1).

"(B) Substantially similar standards followed by a plurality of States, as reflected in existing State laws, relating to the specific process categories described in subparagraphs (A) through (D) of subsection (b)(1).

"(C) Any Federal law requirement related to specific process categories described in sub-

paragraphs (A) through (D) of subsection (b)(1).

"(D) In the case of the adoption of any standard that differs substantially from those referred to in subparagraphs (A), (B), or (C), the Board shall provide evidence to the Secretary that such standard is necessary to protect health insurance consumers or promote speed to market or administrative efficiency.

"(E) The criteria specified in clauses (i) through (iii) of subsection (d)(2)(B).

"(d) RECOMMENDATIONS AND CERTIFICATION BY SECRETARY.—

"(1) RECOMMENDATIONS.—Not later than 18 months after the date on which all members of the Board are selected under subsection (a), the Board shall recommend to the Secretary the certification of the harmonized standards identified pursuant to subsection (c).

"(2) CERTIFICATION.—

"(A) IN GENERAL.—Not later than 120 days after receipt of the Board's recommendations under paragraph (1), the Secretary shall certify the recommended harmonized standards as provided for in subparagraph (B), and issue

such standards in the form of an interim final regulation.

"(B) CERTIFICATION PROCESS.—The Secretary shall establish a process for certifying the recommended harmonized standard, by category, as recommended by the Board under this section. Such process shall—

"(i) ensure that the certified standards for a particular process area achieve regulatory harmonization with respect to health plans on a national basis;

"(ii) ensure that the approved standards are the minimum necessary, with regard to substance and quantity of requirements, to protect health insurance consumers and maintain a competitive regulatory environment; and

"(iii) ensure that the approved standards will not limit the range of group health plan designs and insurance products, such as catastrophic coverage only plans, health savings accounts, and health maintenance organizations, that might otherwise be available to consumers.

"(3) APPLICATION AND EFFECTIVE DATE.—The standards certified by the Secretary under paragraph (2) shall apply and become effective on the date that is 18 months after the date on which the Secretary certifies the harmonized standards.

"(e) TERMINATION.—The Board shall terminate and be dissolved after making the recommendations to the Secretary pursuant to subsection (d)(1).

"(f) ONGOING REVIEW.—Not earlier than 3 years after the termination of the Board under subsection (e), and not earlier than every 3 years thereafter, the Secretary, in consultation with the National Association of Insurance Commissioners and the entities and constituencies represented on the Board and the Advisory Panel, shall prepare and submit to the appropriate committees of Congress a report that assesses the effect of the harmonized standards applied under this section on access, cost, and health insurance market functioning. The Secretary may, based on such report and applying the process established for certification under subsection (d)(2)(B), in consultation with the National Association of Insurance Commissioners and the entities and constituencies represented on the Board and the Advisory Panel, update the harmonized standards through notice and comment rulemaking.

"(g) PUBLICATION.—

"(1) LISTING.—The Secretary shall maintain an up to date listing of all harmonized standards certified under this section on the Internet website of the Department of Health and Human Services.

"(2) SAMPLE CONTRACT LANGUAGE.—The Secretary shall publish on the Internet website of the Department of Health and Human Services sample contract language that incorporates the harmonized standards certified under this section, which may be used by insurers seeking to qualify as an eligible insurer. The types of harmonized standards that shall be included in sample contract language are the standards that are relevant to the contractual bargain between the insurer and insured.

"(h) STATE ADOPTION AND ENFORCEMENT.—Not later than 18 months after the certification by the Secretary of harmonized standards under this section, the States may adopt such harmonized standards (and become an adopting State) and, in which case, shall enforce the harmonized standards pursuant to State law.

"SEC. 2933. APPLICATION AND PREEMPTION.

"(a) SUPERCEDING OF STATE LAW.—

"(1) IN GENERAL.—The harmonized standards certified under this subtitle and applied as provided for in section 2933(d)(3), shall supersede any and

all State laws of a non-adopting State insofar as such State laws relate to the areas of harmonized standards as applied to an eligible insurer, or health insurance coverage issued by a eligible insurer, including with respect to coverage issued to a small business health plan, in a nonadopting State.

"(2) NONADOPTING STATES.—This subtitle shall supersede any and all State laws of a nonadopting State (whether enacted prior to or after the date of enactment of this title) insofar as they may—

"(A) prohibit an eligible insurer from offering, marketing, or implementing health insurance coverage consistent with the harmonized standards; or

"(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing health insurance coverage consistent with the harmonized standards under this subtitle.

"(b) SAVINGS CLAUSE AND CONSTRUCTION.—

"(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting States.

"(2) NONAPPLICATION TO CERTAIN INSURERS.—Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers who offer health insurance coverage in a nonadopting State.

"(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not supercede any State law of a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the harmonized standards under this subtitle.

"(4) NO EFFECT ON PREEMPTION.—In no case shall this subtitle be construed to limit or affect in any manner the preemptive scope of sections 502 and 514 of the Employee Retirement Income Security Act of 1974. In no case shall this subtitle be construed to create any cause of action under Federal or State law or enlarge or affect any remedy available under the Employee Retirement Income Security Act of 1974.

"(c) EFFECTIVE DATE.—This section shall apply beginning on the date that is 18 months after the date on

harmonized standards are certified by the Secretary under this subtitle.

"SEC. 2934. CIVIL ACTIONS AND JURISDICTION.

"(a) IN GENERAL.—The district courts of the United States shall have exclusive jurisdiction over civil actions involving the interpretation of this subtitle.

"(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 2933.

"(c) DIRECT FILING IN COURT OF APPEALS.—At the election of the eligible insurer, an action may be brought under subsection (b) directly in the United States Court of Appeals for the circuit in which the nonadopting State is located by the filing of a petition for review in such Court.

"(d) EXPEDITED REVIEW.—

"(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the

date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

"(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

"(e) STANDARD OF REVIEW.—A court in an action filed under this section, shall render a judgment based on a review of the merits of all questions presented in such action and shall not defer to any conduct or action, or proposed conduct or action, of a nonadopting State.

"SEC. 2935. AUTHORIZATION OF APPROPRIATIONS; RULE OF CONSTRUCTION.

"(a) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this subtitle.

"(b) HEALTH SAVINGS ACCOUNTS.—Nothing in this subtitle shall be construed to create any mandates for cov-

erage of any benefits below the deductible levels set for any health savings account-qualified health plan pursuant to section 223 of the Internal Revenue Code of 1986.".

TITLE III—AFFORDABLE ACCESS TO HEALTH CARE FOR ALL AMERICANS

Subtitle A—Improving the Quality of Health Care by More Effectively Using Health Information Technology

SEC. 300. SHORT TITLE.

This subtitle may be cited as the "Wired for Health Care Quality Act".

PART I—HEALTH INFORMATION TECHNOLOGY

Subpart A—Improving the Interoperability of Health Information Technology

SEC. 301. IMPROVING HEALTH CARE QUALITY, SAFETY, AND EFFICIENCY.

The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

"TITLE XXX—HEALTH INFORMATION TECHNOLOGY AND QUALITY

"SEC. 3001. DEFINITIONS; REFERENCE.

"(a) IN GENERAL.—In this title:

"(1) COMMUNITY.—The term 'Community' means the American Health Information Community established under section 3004.

"(2) HEALTH CARE PROVIDER.—The term 'health care provider' means a hospital, skilled nursing facility, home health entity, health care clinic, federally qualified health center, group practice (as defined in section 1877(h)(4) of the Social Security Act), a pharmacist, a pharmacy, a laboratory, a physician (as defined in section 1861(r) of the Social Security Act), a practitioner (as defined in section 1842(b)(18)(CC) of the Social Security Act), a health facility operated by or pursuant to a contract with the Indian Health Service, a rural health clinic, and any other category of facility or clinician determined appropriate by the Secretary.

"(3) HEALTH INFORMATION.—The term 'health information' has the meaning given such term in section 1171(4) of the Social Security Act.

"(4) HEALTH INSURANCE PLAN.—

"(A) IN GENERAL.—The term 'health insurance plan' means—

"(i) a health insurance issuer (as defined in section 2791(b)(2));

"(ii) a group health plan (as defined in section 2791(a)(1)); and

"(iii) a health maintenance organization (as defined in section 2791(b)(3)); or

"(iv) a safety net health plan.

"(B) SAFETY NET HEALTH PLAN.—The term 'safety net health plan' means a managed care organization, as defined in section 1932(a)(1)(B)(i) of the Social Security Act—

"(i) that is exempt from or not subject to Federal income tax, or that is owned by an entity or entities exempt from or not subject to Federal income tax; and

"(ii) for which not less than 75 percent of the enrolled population receives benefits under a Federal health care program (as defined in section 1128B(f)(1) of the Social Security Act) or a health care plan or program which is funded, in whole or in part, by a State (other than a program for government employees).

"(C) REFERENCES.—All references in this title to 'health plan' shall be deemed to be references to 'health insurance plan'.

"(5) INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.—The term 'individually identifiable health information' has the meaning given such term in section 1171 of the Social Security Act.

"(6) LABORATORY.—The term 'laboratory' has the meaning given such term in section 353.

"(7) NATIONAL COORDINATOR.—The term 'National Coordinator' means the National Coordinator of Health Information Technology appointed pursuant to section 3002.

"(8) PARTNERSHIP.—The term 'Partnership' means the Partnership for Health Care Improvement established under section 3003.

"(9) QUALIFIED HEALTH INFORMATION TECHNOLOGY.—The term 'qualified health information technology' means a computerized system (including hardware and software) that—

"(A) protects the privacy and security of health information;

"(B) maintains and provides permitted access to health information in an electronic format;

"(C) with respect to individually identifiable health information maintained in a designated record set, preserves an audit trail of

each individual that has gained access to such record set;

"(D) incorporates decision support to reduce medical errors and enhance health care quality;

"(E) complies with the standards adopted by the Federal Government under section 3003;

"(F) has the ability to transmit and exchange information to other health information technology systems and, to the extent feasible, public health information technology systems; and

"(G) allows for the reporting of quality measures adopted under section 3010.

"(10) STATE.—The term 'State' means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

"(b) REFERENCES TO SOCIAL SECURITY ACT.—Any reference in this section to the Social Security Act shall be deemed to be a reference to such Act as in effect on the date of enactment of this title.

"SEC. 3002. OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY.

"(a) ESTABLISHMENT.—There is established within the office of the Secretary, the Office of the National Coordinator of Health Information Technology. The National Coordinator shall be appointed by the Secretary in consultation with the President, and shall report directly to the Secretary.

"(b) PURPOSE.—The Office of the National Coordinator shall be responsible for—

"(1) ensuring that key health information technology initiatives are coordinated across programs of the Department of Health and Human Services;

"(2) ensuring that health information technology policies and programs of the Department of Health and Human Services are coordinated with such policies and programs of other relevant Federal agencies (including Federal commissions and advisory committees) with a goal of avoiding duplication of efforts and of helping to ensure that each agency undertakes activities primarily within the areas of its greatest expertise and technical capability;

"(3) reviewing Federal health information technology investments to ensure that Federal health information technology programs are meeting the objectives of the strategic plan published by the Office

of the National Coordinator of Health Information Technology to establish a nationwide interoperable health information technology infrastructure;

"(4) providing comments and advice regarding specific Federal health information technology programs, at the request of Office of Management and Budget; and

"(5) enhancing the use of health information technology to improve the quality of health care in the prevention and management of chronic disease and to address population health.

"(c) ROLE WITH COMMUNITY AND THE PARTNERSHIP.—The Office of the National Coordinator shall—

"(1) serve as an ex officio member of the Community, and act as a liaison between the Federal Government and the Community;

"(2) serve as an ex officio member of the Partnership and act as a liaison between the Federal Government and the Partnership; and

"(3) serve as a liaison between the Partnership and the Community.

"(d) REPORTS AND WEBSITE.—The Office of the National Coordinator shall—

"(1) develop and publish a strategic plan for implementing a nationwide interoperable health information technology infrastructure;

"(2) maintain and frequently update an Internet website that—

"(A) publishes the schedule for the assessment of standards for significant use cases;

"(B) publishes the recommendations of the Community;

"(C) publishes the recommendations of the Partnership;

"(D) publishes quality measures;

"(E) identifies sources of funds that will be made available to facilitate the purchase of, or enhance the utilization of, health information technology systems, either through grants or technical assistance; and

"(F) publishes a plan for a transition of any functions of the Office of the National Coordinator that should be continued after September 30, 2014;

"(3) prepare a report on the lessons learned from major public and private health care systems that have implemented health information technology systems, including an explanation of whether

the systems and practices developed by such systems may be applicable to and usable in whole or in part by other health care providers; and

"(4) assess the impact of health information technology in communities with health disparities and identify practices to increase the adoption of such technology by health care providers in such communities.

"(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as requiring the duplication of Federal efforts with respect to the establishment of the Office of the National Coordinator for Health Information Technology, regardless of whether such efforts are carried out before or after the date of the enactment of this title.

"(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $5,000,000 for each of fiscal years 2008 and 2009.

"(g) SUNSET.—The provisions of this section shall not apply after September 30, 2014.

"SEC. 3003. PARTNERSHIP FOR HEALTH CARE IMPROVEMENT-STANDARDS AND TECHNOLOGY.

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—There is established a public-private Partnership for Health Care Improvement to—

"(A) provide advice to the Secretary and the Nation and recommend specific actions to achieve a nationwide interoperable health information technology infrastructure;

"(B) make recommendations concerning standards, implementation specifications, and certification criteria for the electronic exchange of health information (including for the reporting of quality data under section 3010) for adoption by the Federal Government and voluntary adoption by private entities;

"(C) serve as a forum for the participation of a broad range of stakeholders with specific technical expertise in the development of standards, implementation specifications, and certification criteria to provide input on the effective implementation of health information technology systems; and

"(D) develop and maintain an Internet website that—

"(i) publishes established governance rules (including a subsequent appointment process);

"(ii) publishes a business plan;

"(iii) publishes meeting notices at least 14 days prior to each meeting;

"(iv) publishes meeting agendas at least 7 days prior to each meeting; and

"(v) publishes meeting materials at least 3 days prior to each meeting.

"(2) LIMITATION.—The Partnership shall not meet or take any action until an advisory committee charter has been filed with the Secretary and with the appropriate committees of the Senate and House of Representatives for the Community described in section 3004.

"(b) MEMBERSHIP.—

"(1) APPOINTMENTS.—

"(A) IN GENERAL.—The Partnership shall be composed of members to be appointed as follows:

"(i) 2 members shall be appointed by the Secretary.

"(ii) 1 member shall be appointed by the majority leader of the Senate.

"(iii) 1 member shall be appointed by the minority leader of the Senate.

"(iv) 1 member shall be appointed by the Speaker of the House of Representatives.

"(v) 1 member shall be appointed by the minority leader of the House of Representatives.

"(vi) Seven members shall be appointed by the Comptroller General of whom—

"(I) one member shall be a representative of consumer or patient organizations;

"(II) one member shall be a representative of organizations with expertise in privacy;

"(III) one member shall be a representative of organizations with expertise in security;

"(IV) one member shall be a representative of health care providers;

"(V) one member shall be a representative of health plans or other third party payers;

"(VI) one member shall be a representative of information technology vendors; and

"(VII) one member shall be a representative of purchasers or employers.

"(B) NATIONAL COORDINATOR.—The National Coordinator shall be a member of the Partnership and act as a liaison among the Partnership, the community, and the Federal Government.

"(2) CHAIRPERSON AND VICE CHAIRPERSON.—The Partnership shall designate one member to serve as the chairperson and one member to serve as the vice chairperson of the Partnership.

"(3) PARTICIPATION.—In appointing members under paragraph (1)(A), and in developing the procedures for conducting the activities of the Partnership, the Partnership shall ensure a balance among various sectors of the health care system so that no single sector unduly influences the recommendations of the Partnership.

"(4) TERMS.—Members appointed under paragraph (1)(A) shall serve for 3 year terms, except that any member appointed to fill a vacancy for an

unexpired term shall be appointed for the remainder of such term. A member may serve for not to exceed 180 days after the expiration of such member's term or until a successor has been appointed.

"(5) OUTSIDE INVOLVEMENT.—The Partnership shall ensure an adequate opportunity for the participation of outside advisors, including individuals with expertise in—

"(A) health information privacy;

"(B) health information security;

"(C) health care quality and patient safety, including individuals with expertise in utilizing health information technology to improve health care quality and patient safety;

"(D) medical and clinical research data exchange; and

"(E) developing health information technology standards and new health information technology.

"(6) QUORUM.—Two-thirds of the members of the Partnership shall constitute a quorum for the purpose of conducting votes.

"(c) STANDARDS AND IMPLEMENTATION SPECIFICATIONS.—

"(1) SCHEDULE.—Not later than 90 days after the date of enactment of this title, the Partnership shall develop a schedule for the assessment of standards and implementation specifications under this section. The Partnership shall update such schedule annually. The Secretary shall publish such schedule in the Federal Register and on the Internet website of the Department of Health and Human Services.

"(2) FIRST YEAR RECOMMENDATIONS.—Consistent with the schedule published under paragraph (1) and not later than 1 year after date of enactment of this title, the Partnership shall recommend, and the Secretary shall review, such standards and implementation specifications.

"(3) ONGOING RECOMMENDATIONS.—The Partnership shall review and modify, as appropriate but at least annually, adopted standards and implementation specifications and continue to recommend additional standards and implementation specifications, consistent with the schedule published pursuant to paragraph (1). The Secretary shall review such modifications and recommendations.

"(4) RECOGNITION OF PRIVATE ENTITIES.—The Partnership, in consultation with the Secretary, may recognize a private entity or entities for the

purpose of developing and updating standards and implementation specifications to achieve uniform and consistent implementation of the standards adopted by the President under this title. Such entity or entities shall make recommendations to the Partnership consistent with this section.

"(5) PUBLICATION.—All recommendations made by the Partnership pursuant to this section shall be published in the Federal Register and on the Internet website of the Office of the National Coordinator.

"(6) PILOT TESTING.—The Secretary may conduct, or recognize a private entity or entities to conduct, a pilot project to test the standards and implementation specifications developed under this section in order to provide for the efficient implementation of the standards and implementation specifications described in this subsection prior to issuing such recommendations.

"(7) PUBLIC INPUT.—The Partnership shall conduct open public meetings and develop a process to allow for public comment on the schedule and recommendations described in this section. Such process shall ensure that such comments will be sub-

mitted within 30 days of the publication of a recommendation under this section.

"(8) FEDERAL ACTION.—Not later than 90 days after the issuance of a recommendation from the Partnership under this subsection, the Secretary, the Secretary of Veterans Affairs, and the Secretary of Defense, in collaboration with representatives of other relevant Federal agencies as determined appropriate by the President, shall jointly review such recommendation. If appropriate, the President shall provide for the adoption by the Federal Government of any standard or implementation specification contained in such recommendation. Such determination shall be published in the Federal Register and on the Internet website of the Office of the National Coordinator within 30 days after such determination is made.

"(9) CONSISTENCY.—The standards and implementation specifications described in this subsection shall be consistent with the standards for information transactions and data elements developed pursuant to the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

"(d) CERTIFICATION.—

"(1) DEVELOPING CRITERIA.—The Partnership, in consultation with the Secretary, may recognize a private entity or entities for the purpose of developing and recommending to the Partnership criteria to certify that appropriate categories of health information technology products that claim to be in compliance with applicable standards and implementation specifications adopted under this title have established such compliance.

"(2) ADOPTION OF CRITERIA.—The Secretary, based upon the recommendations of the Partnership, shall review, and if appropriate, adopt such criteria.

"(3) CONDUCTING CERTIFICATION.—The Secretary may recognize a private entity or entities to conduct the certifications described under paragraph (1) using the criteria adopted by the Secretary under this subsection.

"(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as disrupting existing activities described in subsection (c) or (d).

"(f) REQUIREMENT TO CONSIDER RECOMMENDATIONS.—In carrying out the activities described in subsections (c) and (d), the Partnership shall adopt and integrate the recommendations of the Community that are adopted by the Secretary.

"(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $2,000,000 for each of the fiscal years 2008 and 2009.

"SEC. 3004. AMERICAN HEALTH INFORMATION COMMUNITY—POLICIES.

"(a) ESTABLISHMENT.—There is established a committee to be known as the American Health Information Community. The Community shall—

"(1) provide advice to the Secretary and the heads of any relevant Federal agencies concerning the policy considerations related to health information technology;

"(2) not later than 1 year after the date of enactment of this title, and annually thereafter, make recommendations concerning a policy framework for the development and adoption of a nationwide interoperable health information technology infrastructure;

"(3) not later than 1 year after the date of enactment of this title, and annually thereafter, make recommendation concerning national policies for adoption by the Federal Government, and voluntary adoption by private entities, to support the widespread adoption of health information technology, including—

"(A) the protection of individually identifiable health information, including policies concerning the individual's ability to control the acquisition, uses, and disclosures of individually identifiable health information;

"(B) methods to protect individually identifiable health information from improper use and disclosures and methods to notify patients if their individually identifiable health information is wrongfully disclosed;

"(C) methods to facilitate secure access to such individual's individually identifiable health information;

"(D) the appropriate uses of a nationwide health information network including—

"(i) the collection of quality data and public reporting;

"(ii) biosurveillance and public health;

"(iii) medical and clinical research; and

"(iv) drug safety;

"(E) fostering the public understanding of health information technology;

"(F) strategies to enhance the use of health information technology in preventing and managing chronic disease;

"(G) policies to incorporate the input of employees of health care providers in the design and implementation of health information technology systems; and

"(H) other policies determined to be necessary by the Community; and

"(4) serve as a forum for the participation of a broad range of stakeholders to provide input on improving the effective implementation of health information technology systems.

"(b) PUBLICATION.—All recommendations made by the Community pursuant to this section shall be published in the Federal Register and on the Internet website of the National Coordinator. The Secretary shall review all recommendations and determine which recommendations shall be endorsed by the Federal Government and such determination shall be published on the Internet website of the Office of the National Coordinator within 30 days after the date on which such endorsement is made.

"(c) MEMBERSHIP.—

"(1) IN GENERAL.—The Community shall be composed of members to be appointed as follows:

"(A) 3 members shall be appointed by the Secretary, 1 of whom shall be a representative from the Department of Health and Human Services.

"(B) 1 member shall be appointed by the Secretary of Veterans Affairs who shall represent the Department of Veterans Affairs.

"(C) 1 member shall be appointed by the Secretary of Defense who shall represent the Department of Defense.

"(D) 1 member shall be appointed by the majority leader of the Senate.

"(E) 1 member shall be appointed by the minority leader of the Senate.

"(F) 1 member shall be appointed by the Speaker of the House of Representatives.

"(G) 1 member shall be appointed by the minority leader of the House of Representatives.

"(H) Nine members shall be appointed by the Comptroller General of whom—

"(i) one member shall be advocates for patients or consumers;

"(ii) one member shall represent health care providers;

"(iii) one member shall be from a labor organization representing health care workers;

"(iv) one member shall have expertise in privacy and security;

"(v) one member shall have expertise in improving the health of vulnerable populations;

"(vi) one member shall represent health plans or other third party payers;

"(vii) one member shall represent information technology vendors;

"(viii) one member shall represent purchasers or employers; and

"(ix) one member shall have expertise in health care quality measurement and reporting.

"(2) CHAIRPERSON AND VICE CHAIRPERSON.—The Community shall designate one member to serve as the chairperson and one member to serve as the vice chairperson of the Community.

"(3) NATIONAL COORDINATOR.—The National Coordinator shall be a member of the Community and act as a liaison among the Community, the partnership, and the Federal Government.

"(4) PARTICIPATION.—The members of the Community appointed under paragraph (1) shall represent a balance among various sectors of the health care system so that no single sector unduly influences the recommendations of the Community.

"(5) TERMS.—

"(A) IN GENERAL.—The terms of members of the Community shall be for 3 years except that the Comptroller General shall designate staggered terms for the members first appointed.

"(B) VACANCIES.—Any member appointed to fill a vacancy in the membership of the Community that occurs prior to the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has been appointed. A vacancy in the Community shall be filled in the manner in which the original appointment was made.

"(6) OUTSIDE INVOLVEMENT.—The Community shall ensure an adequate opportunity for the participation of outside advisors, including individuals with expertise in—

"(A) health information privacy and security;

"(B) improving the health of vulnerable populations;

"(C) health care quality and patient safety, including individuals with expertise in measurement and the use of health information technology to capture data to improve health care quality and patient safety;

"(D) ethics;

"(E) medical and clinical research data exchange; and

"(F) developing health information technology standards and new health information technology.

"(7) QUORUM.—Ten members of the Community shall constitute a quorum for purposes of voting, but a lesser number of members may meet and hold hearings.

"(d) FEDERAL AGENCIES.—

"(1) STAFF OF OTHER FEDERAL AGENCIES.—Upon the request of the Community, the head of any Federal agency may detail, without reimbursement, any of the personnel of such agency to the Community to assist in carrying out the duties of the Com-

munity. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee involved.

"(2) TECHNICAL ASSISTANCE.—Upon the request of the Community, the head of a Federal agency shall provide such technical assistance to the Community as the Community determines to be necessary to carry out its duties.

"(3) OTHER RESOURCES.—The Community shall have reasonable access to materials, resources, statistical data, and other information from the Library of Congress and agencies and elected representatives of the executive and legislative branches of the Federal Government. The chairperson or vice chairperson of the Community shall make requests for such access in writing when necessary.

"(e) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the Community, except that the term provided for under section 14(a)(2) of such Act shall be not longer than 7 years.

"(f) SUNSET.—The provisions of this section shall not apply after September 20, 2014.

"(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $2,000,000 for each of fiscal years 2008 and 2009.

"SEC. 3005. FEDERAL PURCHASING AND DATA COLLECTION.

"(a) COORDINATION OF FEDERAL SPENDING.—

"(1) IN GENERAL.—Not later than 1 year after the adoption by the President of a recommendation under section 3003(c)(6), a Federal agency shall not expend Federal funds for the purchase of any new health information technology or health information technology system for clinical care or for the electronic retrieval, storage, or exchange of health information if such technology or system is not consistent with applicable standards adopted by the Federal Government under section 3003.

"(2) RULE OF CONSTRUCTION.—Nothing in paragraph (1) shall be construed to restrict the purchase of minor (as determined by the Secretary) hardware or software components in order to modify, correct a deficiency in, or extend the life of existing hardware or software.

"(b) VOLUNTARY ADOPTION.—

"(1) IN GENERAL.—Any standards and implementation specifications adopted by the Federal Government under section 303(c)(6) shall be voluntary with respect to private entities.

"(2) REQUIREMENT.—Private entities that enter into a contract with the Federal Government

shall adopt the standards and implementation specifications adopted by the Federal Government under this section for the purpose of activities under such Federal contract.

"(3) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require that a private entity that enters into a contract with the Federal Government adopt the standards and implementation specifications adopted by the Federal Government under this section with respect to activities not related to the contract.

"(c) COORDINATION OF FEDERAL DATA COLLECTION.—Not later than 3 years after the adoption by the Federal Government of a recommendation as provided for in section 303(c)(6), all Federal agencies collecting health data in an electronic format for the purposes of quality reporting, surveillance, epidemiology, adverse event reporting, research, or for other purposes determined appropriate by the Secretary, shall comply with the standards and implementation specifications adopted under such subsection.

"SEC. 3006. QUALITY AND EFFICIENCY REPORTS.

"(a) PURPOSE.—The purpose of this section is to provide for the development of reports based on Federal health care data and private data that is publicly available

or is provided by the entity making the request for the report in order to—

"(1) improve the quality and efficiency of health care and advance health care research;

"(2) enhance the education and awareness of consumers for evaluating health care services; and

"(3) provide the public with reports on national, regional, and provider- and supplier-specific performance, which may be in a provider- or supplier-identifiable format.

"(b) PROCEDURES FOR THE DEVELOPMENT OF REPORTS.—

"(1) IN GENERAL.—Notwithstanding section 552(b)(6) or 552a(b) of title 5, United States Code, not later than 12 months after the date of enactment of this section, the Secretary, in accordance with the purpose described in subsection (a), shall establish and implement procedures under which an entity may submit a request to a Quality Reporting Organization for the Organization to develop a report based on—

"(A) Federal health care data disclosed to the Organization under subsection (c); and

"(B) private data that is publicly available or is provided to the Organization by the entity making the request for the report.

"(2) DEFINITIONS.—In this section:

"(A) FEDERAL HEALTH CARE DATA.—The term 'Federal health care data' means —

"(i) deidentified patient enrollment data, reimbursement claims, and survey data maintained by the Secretary or entities under programs, contracts, grants, or memoranda of understanding administered by the Secretary; and

"(ii) where feasible, other deidentified patient enrollment data, reimbursement claims, and survey data maintained by the Federal Government or entities under contract with the Federal Government.

"(B) QUALITY REPORTING ORGANIZATION.—The term 'Quality Reporting Organization' means an entity with a contract under subsection (d).

"(c) ACCESS TO FEDERAL HEALTH CARE DATA.—

"(1) IN GENERAL.—The procedures established under subsection (b)(1) shall provide for the secure

disclosure of Federal health care data to each Quality Reporting Organization.

"(2) UPDATE OF INFORMATION.—Not less than every 6 months, the Secretary shall update the information disclosed under paragraph (1) to Quality Reporting Organizations.

"(d) QUALITY REPORTING ORGANIZATIONS.—

"(1) IN GENERAL.—

"(A) THREE CONTRACTS.—Subject to subparagraph (B), the Secretary shall enter into a contract with 3 private entities to serve as Quality Reporting Organizations under which an entity shall—

"(i) store the Federal health care data that is to be disclosed under subsection (c); and

"(ii) develop and release reports pursuant to subsection (e).

"(B) ADDITIONAL CONTRACTS.—If the Secretary determines that reports are not being developed and released within 6 months of the receipt of the request for the report, the Secretary shall enter into contracts with additional private entities in order to ensure that such re-

ports are developed and released in a timely manner.

"(2) QUALIFICATIONS.—The Secretary shall enter into a contract with an entity under paragraph (1) only if the Secretary determines that the entity—

"(A) has the research capability to conduct and complete reports under this section;

"(B) has in place–

"(i) an information technology infrastructure to support the database of Federal health care data that is to be disclosed to the entity; and

"(ii) operational standards to provide security for such database;

"(C) has experience with, and expertise on, the development of reports on health care quality and efficiency; and

"(D) has a significant business presence in the United States.

"(3) CONTRACT REQUIREMENTS.—Each contract with an entity under paragraph (1) shall contain the following requirements:

"(A) ENSURING BENEFICIARY PRIVACY.—

"(i) HIPAA.—The entity shall meet the requirements imposed on a covered entity for purposes of applying part C of title XI and all regulatory provisions promulgated thereunder, including regulations (relating to privacy) adopted pursuant to the authority of the Secretary under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note).

"(ii) PRIVACY.—The entity shall provide assurances that the entity will not use the Federal health care data disclosed under subsection (c) in a manner that violates sections 552 or 552a of title 5, United States Code, with regard to the privacy of and individual's individually identifiable health information.

"(B) PROPRIETARY INFORMATION.—The entity shall provide assurances that the entity will not disclose any negotiated price concessions, such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations, obtained by health care providers or sup-

pliers or health care plans, or any other proprietary cost information.

"(C) DISCLOSURE.—The entity shall disclose—

"(i) any financial, reporting, or contractual relationship between the entity and any health care provider or supplier or health care plan; and

"(ii) if applicable, the fact that the entity is managed, controlled, or operated by any health care provider or supplier or health care plan.

"(D) COMPONENT OF ANOTHER ORGANIZATION.—If the entity is a component of another organization—

"(i) the entity shall maintain Federal health care data and reports separately from the rest of the organization and establish appropriate security measures to maintain the confidentiality and privacy of the Federal health care data and reports; and

"(ii) the entity shall not make an unauthorized disclosure to the rest of the organization of Federal health care data or

reports in breach of such confidentiality and privacy requirement.

"(E) TERMINATION OR NONRENEWAL.—If a contract under this section is terminated or not renewed, the following requirements shall apply:

"(i) CONFIDENTIALITY AND PRIVACY PROTECTIONS.—The entity shall continue to comply with the confidentiality and privacy requirements under this section with respect to all Federal health care data disclosed to the entity and each report developed by the entity.

"(ii) DISPOSITION OF DATA AND REPORTS.—The entity shall—

"(I) return to the Secretary all Federal health care data disclosed to the entity and each report developed by the entity; or

"(II) if returning the Federal health care data and reports is not practicable, destroy the reports and Federal health care data.

"(4) COMPETITIVE PROCEDURES.—Competitive procedures (as defined in section 4(5) of the Federal

Procurement Policy Act) shall be used to enter into contracts under paragraph (1).

"(5) REVIEW OF CONTRACT IN THE EVENT OF A MERGER OR ACQUISITION.—The Secretary shall review the contract with a Quality Reporting Organization under this section in the event of a merger or acquisition of the Organization in order to ensure that the requirements under this section will continue to be met.

"(e) DEVELOPMENT AND RELEASE OF REPORTS BASED ON REQUESTS.—

"(1) REQUEST FOR A REPORT.—

"(A) REQUEST.—

"(i) IN GENERAL.—The procedures established under subsection (b)(1) shall include a process for an entity to submit a request to a Quality Reporting Organization for a report based on Federal health care data and private data that is publicly available or is provided by the entity making the request for the report. Such request shall comply with the purpose described in subsection (a).

"(ii) REQUEST FOR SPECIFIC METHODOLOGY.—The process described in

clause (i) shall permit an entity making a request for a report to request that a specific methodology, including appropriate risk adjustment, be used by the Quality Reporting Organization in developing the report. The Organization shall work with the entity making the request to finalize the methodology to be used.

"(iii) REQUEST FOR A SPECIFIC QRO.—The process described in clause (i) shall permit an entity to submit the request for a report to any Quality Reporting Organization.

"(B) RELEASE TO PUBLIC.—The procedures established under subsection (b)(1) shall provide that at the time a request for a report is finalized under subparagraph (A) by a Quality Reporting Organization, the Organization shall make available to the public, through the Internet website of the Department of Health and Human Services and other appropriate means, a brief description of both the requested report and the methodology to be used to develop such report.

"(2) DEVELOPMENT AND RELEASE OF REPORT.—

"(A) DEVELOPMENT.—

"(i) IN GENERAL.—If the request for a report complies with the purpose described in subsection (a), the Quality Reporting Organization may develop the report based on the request.

"(ii) REQUIREMENT.—A report developed under clause (i) shall include a detailed description of the standards, methodologies, and measures of quality used in developing the report.

"(B) REVIEW OF REPORT BY SECRETARY TO ENSURE COMPLIANCE WITH PRIVACY REQUIREMENT.—Prior to a Quality Reporting Organization releasing a report under subparagraph (C), the Secretary shall review the report to ensure that the report complies with the Federal regulations (concerning the privacy of individually identifiable beneficiary health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 and sections 552 or 552a of title 5, United States Code, with regard to the

privacy of individually identifiable beneficiary health information. The Secretary shall act within 30 business days of receiving such report.

"(C) RELEASE OF REPORT.—

"(i) RELEASE TO ENTITY MAKING REQUEST.—If the Secretary finds that the report complies with the provisions described in subparagraph (B), the Quality Reporting Organization shall release the report to the entity that made the request for the report.

"(ii) RELEASE TO PUBLIC.—The procedures established under subsection (b)(1) shall provide for the following:

"(I) UPDATED DESCRIPTION.—At the time of the release of a report by a Quality Reporting Organization under clause (i), the entity shall make available to the public, through the Internet website of the Department of Health and Human Services and other appropriate means, an updated brief description of both the requested

report and the methodology used to develop such report.

"(II) COMPLETE REPORT.—Not later than 1 year after the date of the release of a report under clause (i), the report shall be made available to the public through the Internet website of the Department of Health and Human Services and other appropriate means.

"(f) ANNUAL REVIEW OF REPORTS AND TERMINATION OF CONTRACTS.—

"(1) ANNUAL REVIEW OF REPORTS.—The Comptroller General of the United States shall review reports released under subsection (e)(2)(C) to ensure that such reports comply with the purpose described in subsection (a) and annually submit a report to the Secretary on such review.

"(2) TERMINATION OF CONTRACTS.—The Secretary may terminate a contract with a Quality Reporting Organization if the Secretary determines that there is a pattern of reports being released by the Organization that do not comply with the purpose described in subsection (a).

"(g) FEES.—

"(1) FEES FOR SECRETARY.—The Secretary shall charge a Quality Reporting Organization a fee for—

"(A) disclosing the data under subsection (c); and

"(B) conducting the review under subsection (e)(2)(B).

The Secretary shall ensure that such fees are sufficient to cover the costs of the activities described in subparagraph (A) and (B).

"(2) FEES FOR QRO.—

"(A) IN GENERAL.—Subject to subparagraphs (A) and (B), a Quality Reporting Organization may charge an entity making a request for a report a reasonable fee for the development and release of the report.

"(B) DISCOUNT FOR SMALL ENTITIES.—In the case of an entity making a request for a report (including a not-for-profit) that has annual revenue that does not exceed $10,000,000, the Quality Reporting Organization shall reduce the reasonable fee charged to such entity under subparagraph (A) by an amount equal to 10 percent of such fee.

"(C) INCREASE FOR LARGE ENTITIES THAT DO NOT AGREE TO RELEASE REPORTS WITHIN 6 MONTHS.—In the case of an entity making a request for a report that is not described in subparagraph (B) and that does not agree to the report being released to the public under clause (ii)(II) of subsection (e)(2)(C) within 6 months of the date of the release of the report to the entity under clause (i) of such subsection, the Quality Reporting Organization shall increase the reasonable fee charged to such entity under subparagraph (A) by an amount equal to 10 percent of such fee.

"(D) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed to effect the requirement that a report be released to the public under clause (ii)(II) of subsection (e)(2)(C)(ii)(II) by not later than 1 year after the date of the release of the report to the requesting entity under clause (i) of such subsection.

"(h) COORDINATION.—Not later than 1 year after the date of enactment of this title, the Secretary shall submit a report (including recommendations) to the appro-

priate committees of Congress concerning the coordination of existing Federal health care quality initiatives.

"(i) REGULATIONS.—Not later than 6 months after the date of enactment of this section, the Secretary shall prescribe regulations to carry out this section.

"SEC. 3007. RESEARCH ACCESS TO HEALTH CARE DATA AND REPORTING ON PERFORMANCE.

"The Secretary shall permit researchers that meet criteria used to evaluate the appropriateness of the release data for research purpose (as established by the Secretary) to—

"(1) have access to all Federal health care data (as defined in section 3006(b)(2)(A)); and

"(2) report on the performance of health care providers and suppliers, including reporting in a provider- or supplier-identifiable format.".

Subpart B—Facilitating the Widespread Adoption of Interoperable Health Information Technology

SEC. 305. FACILITATING THE WIDESPREAD ADOPTION OF INTEROPERABLE HEALTH INFORMATION TECHNOLOGY.

Title XXX of the Public Health Service Act, as added by section 301, is amended by adding at the end the following:

"SEC. 3008. FACILITATING THE WIDESPREAD ADOPTION OF INTEROPERABLE HEALTH INFORMATION TECHNOLOGY.

"(a) COMPETITIVE GRANTS FOR ADOPTION OF TECHNOLOGY.—

"(1) IN GENERAL.—The Secretary may award competitive grants to eligible entities to facilitate the purchase and enhance the utilization of qualified health information technology systems to improve the quality and efficiency of health care.

"(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1) an entity shall—

"(A) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

"(B) submit to the Secretary a strategic plan for the implementation of data sharing and interoperability measures;

"(C) adopt the standards adopted by the Federal Government under section 3005;

"(D) implement the measures adopted under section 3010 and report to the Secretary on such measures;

"(E) agree to notify individuals if their individually identifiable health information is wrongfully disclosed;

"(F) take into account the input of employees and staff who are directly involved in patient care of such health care providers in the design, implementation, and use of qualified health information technology systems;

"(G) demonstrate significant financial need;

"(H) provide matching funds in accordance with paragraph (4); and

"(I) be a—

"(i) public or not for profit hospital;

"(ii) federally qualified health center (as defined in section 1861(aa)(4) of the Social Security Act);

"(iii) individual or group practice (or a consortium thereof); or

"(iv) another health care provider not described in clause (i) or (ii);

that serves medically underserved communities.

"(3) USE OF FUNDS.—Amounts received under a grant under this subsection shall be used to—

"(A) facilitate the purchase of qualified health information technology systems;

"(B) train personnel in the use of such systems;

"(C) enhance the utilization of qualified health information technology systems (which may include activities to increase the awareness among consumers of health care privacy protections); or

"(D) improve the prevention and management of chronic disease.

"(4) MATCHING REQUIREMENT.—To be eligible for a grant under this subsection an entity shall contribute non-Federal contributions to the costs of carrying out the activities for which the grant is awarded in an amount equal to $1 for each $3 of Federal funds provided under the grant.

"(5) PREFERENCE IN AWARDING GRANTS.—In awarding grants under this subsection the Secretary shall give preference to—

"(A) eligible entities that will improve the degree to which such entity will link the qualified health information system to local or regional health information plan or plans; and

"(B) with respect to awards made for the purpose of providing care in an outpatient medical setting, entities that organize their practices as a patient-centered medical home.

"(b) COMPETITIVE GRANTS FOR THE DEVELOPMENT OF STATE LOAN PROGRAMS TO FACILITATE THE WIDESPREAD ADOPTION OF HEALTH INFORMATION TECHNOLOGY.—

"(1) IN GENERAL.—The Secretary may award competitive grants to States for the establishment of State programs for loans to health care providers to facilitate the purchase and enhance the utilization of qualified health information technology.

"(2) ESTABLISHMENT OF FUND.—To be eligible to receive a competitive grant under this subsection, a State shall establish a qualified health information technology loan fund (referred to in this subsection as a 'State loan fund') and comply with the other requirements contained in this subsection. Amounts received under a grant under this subsection shall be deposited in the State loan fund established by the State. No funds authorized by other provisions of this title to be used for other purposes specified in this title shall be deposited in any such State loan fund.

"(3) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1) a State shall—

"(A) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

"(B) submit to the Secretary a strategic plan in accordance with paragraph (4);

"(C) establish a qualified health information technology loan fund in accordance with paragraph (2);

"(D) require that health care providers receiving loans under the grant—

"(i) link, to the extent practicable, the qualified health information system to a local or regional health information network;

"(ii) consult, as needed, with the Health Information Technology Resource Center established in section 914(d) to access the knowledge and experience of existing initiatives regarding the successful implementation and effective use of health information technology;

"(iii) agree to notify individuals if their individually identifiable health information is wrongfully disclosed; and

"(iv) take into account the input of employees and staff who are directly involved in patient care of such health care providers in the design and implementation and use of qualified health information technology systems;

"(E) require that health care providers receiving loans under the grant adopt the standards adopted by the Federal Government under section 3005;

"(F) require that health care providers receiving loans under the grant implement the measures adopted under section 3010 and report to the Secretary on such measures; and

"(G) provide matching funds in accordance with paragraph (8).

"(4) STRATEGIC PLAN.—

"(A) IN GENERAL.—A State that receives a grant under this subsection shall annually prepare a strategic plan that identifies the intended uses of amounts available to the State loan fund of the State.

"(B) CONTENTS.—A strategic plan under subparagraph (A) shall include—

"(i) a list of the projects to be assisted through the State loan fund in the first fiscal year that begins after the date on which the plan is submitted;

"(ii) a description of the criteria and methods established for the distribution of funds from the State loan fund;

"(iii) a description of the financial status of the State loan fund and the short-term and long-term goals of the State loan fund; and

"(iv) a description of the strategies the State will use to address challenges in the adoption of health information technology due to limited broadband access.

"(5) USE OF FUNDS.—

"(A) IN GENERAL.—Amounts deposited in a State loan fund, including loan repayments and interest earned on such amounts, shall be used only for awarding loans or loan guarantees, or as a source of reserve and security for leveraged loans, the proceeds of which are deposited in the State loan fund established under

paragraph (1). Loans under this section may be used by a health care provider to—

"(i) facilitate the purchase of qualified health information technology systems;

"(ii) enhance the utilization of qualified health information technology systems (which may include activities to increase the awareness among consumers of health care of privacy protections and privacy rights); or

"(iii) train personnel in the use of such systems.

"(B) LIMITATION.—Amounts received by a State under this subsection may not be used—

"(i) for the purchase or other acquisition of any health information technology system that is not a qualified health information technology system;

"(ii) to conduct activities for which Federal funds are expended under this title, or the amendments made by the Wired for Health Care Quality Act; or

"(iii) for any purpose other than making loans to eligible entities under this section.

"(6) TYPES OF ASSISTANCE.—Except as otherwise limited by applicable State law, amounts deposited into a State loan fund under this subsection may only be used for the following:

"(A) To award loans that comply with the following:

"(i) The interest rate for each loan shall be less than or equal to the market interest rate.

"(ii) The principal and interest payments on each loan shall commence not later than 1 year after the date on which the loan was awarded, and each loan shall be fully amortized not later than 10 years after such date.

"(iii) The State loan fund shall be credited with all payments of principal and interest on each loan awarded from the fund.

"(B) To guarantee, or purchase insurance for, a local obligation (all of the proceeds of which finance a project eligible for assistance under this subsection) if the guarantee or purchase would improve credit market access or re-

duce the interest rate applicable to the obligation involved.

"(C) As a source of revenue or security for the payment of principal and interest on revenue or general obligation bonds issued by the State if the proceeds of the sale of the bonds will be deposited into the State loan fund.

"(D) To earn interest on the amounts deposited into the State loan fund.

"(7) ADMINISTRATION OF STATE LOAN FUNDS.—

"(A) COMBINED FINANCIAL ADMINISTRATION.—A State may (as a convenience and to avoid unnecessary administrative costs) combine, in accordance with State law, the financial administration of a State loan fund established under this subsection with the financial administration of any other revolving fund established by the State if not otherwise prohibited by the law under which the State loan fund was established.

"(B) COST OF ADMINISTERING FUND.—Each State may annually use not to exceed 4 percent of the funds provided to the State under a grant under this subsection to pay the

reasonable costs of the administration of the programs under this section, including the recovery of reasonable costs expended to establish a State loan fund which are incurred after the date of enactment of this title.

"(C) GUIDANCE AND REGULATIONS.—The Secretary shall publish guidance and promulgate regulations as may be necessary to carry out the provisions of this subsection, including—

"(i) provisions to ensure that each State commits and expends funds allotted to the State under this subsection as efficiently as possible in accordance with this title and applicable State laws; and

"(ii) guidance to prevent waste, fraud, and abuse.

"(D) PRIVATE SECTOR CONTRIBUTIONS.—

"(i) IN GENERAL.—A State loan fund established under this subsection may accept contributions from private sector entities, except that such entities may not specify the recipient or recipients of any loan issued under this subsection.

"(ii) AVAILABILITY OF INFORMATION.—A State shall make publicly available the identity of, and amount contributed by, any private sector entity under clause (i) and may issue letters of commendation or make other awards (that have no financial value) to any such entity.

"(8) MATCHING REQUIREMENTS.—

"(A) IN GENERAL.—The Secretary may not make a grant under paragraph (1) to a State unless the State agrees to make available (directly or through donations from public or private entities) non-Federal contributions in cash toward the costs of the State program to be implemented under the grant in an amount equal to not less than $1 for each $1 of Federal funds provided under the grant.

"(B) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION.—In determining the amount of non-Federal contributions that a State has provided pursuant to subparagraph (A), the Secretary may not include any amounts provided to the State by the Federal Government.

"(9) PREFERENCE IN AWARDING GRANTS.—The Secretary may give a preference in awarding grants under this subsection to States that adopt value-based purchasing programs to improve health care quality.

"(10) REPORTS.—The Secretary shall annually submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate, and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives, a report summarizing the reports received by the Secretary from each State that receives a grant under this subsection.

"(c) COMPETITIVE GRANTS FOR THE IMPLEMENTATION OF REGIONAL OR LOCAL HEALTH INFORMATION TECHNOLOGY PLANS.—

"(1) IN GENERAL.—The Secretary may award competitive grants to eligible entities to implement regional or local health information plans to improve health care quality and efficiency through the electronic exchange of health information pursuant to the standards, implementation specifications and certification criteria, and other requirements adopted by the Secretary under section 3010.

"(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1) an entity shall—

"(A) demonstrate financial need to the Secretary;

"(B) demonstrate that one of its principal missions or purposes is to use information technology to improve health care quality and efficiency;

"(C) adopt bylaws, memoranda of understanding, or other charter documents that demonstrate that the governance structure and decisionmaking processes of such entity allow for participation on an ongoing basis by multiple stakeholders within a community, including—

"(i) health care providers (including health care providers that provide services to low income and underserved populations);

"(ii) pharmacists or pharmacies;

"(iii) health plans;

"(iv) health centers (as defined in section 330(b)) and federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act) and rural health clinics (as defined in section

1861(aa) of the Social Security Act), if such centers or clinics are present in the community served by the entity;

"(v) patient or consumer organizations;

"(vi) organizations dedicated to improving the health of vulnerable populations;

"(vii) employers;

"(viii) State or local health departments; and

"(ix) any other health care providers or other entities, as determined appropriate by the Secretary;

"(D) demonstrate the participation, to the extent practicable, of stakeholders in the electronic exchange of health information within the local or regional plan pursuant to subparagraph (C);

"(E) adopt nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory participation in the health information plan by all stakeholders;

"(F) adopt the standards adopted by the Secretary under section 3005;

"(G) require that health care providers receiving such grants—

"(i) implement the measures adopted under section 3010 and report to the Secretary on such measures; and

"(ii) take into account the input of employees and staff who are directly involved in patient care of such health care providers in the design, implementation, and use of health information technology systems;

"(H) agree to notify individuals if their individually identifiable health information is wrongfully disclosed;

"(I) facilitate the electronic exchange of health information within the local or regional area and among local and regional areas;

"(J) prepare and submit to the Secretary an application in accordance with paragraph (3);

"(K) agree to provide matching funds in accordance with paragraph (5); and

"(L) reduce barriers to the implementation of health information technology by providers.

"(3) APPLICATION.—

"(A) IN GENERAL.—To be eligible to receive a grant under paragraph (1), an entity shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

"(B) REQUIRED INFORMATION.—At a minimum, an application submitted under this paragraph shall include—

"(i) clearly identified short-term and long-term objectives of the regional or local health information plan;

"(ii) a technology plan that complies with the standards, implementation specifications, and certification criteria adopted under section 3003(c)(6) and that includes a descriptive and reasoned estimate of costs of the hardware, software, training, and consulting services necessary to implement the regional or local health information plan;

"(iii) a strategy that includes initiatives to improve health care quality and ef-

ficiency, including the use and reporting of health care quality measures adopted under section 3010;

"(iv) a plan that describes provisions to encourage the implementation of the electronic exchange of health information by all health care providers participating in the health information plan;

"(v) a plan to ensure the privacy and security of individually identifiable health information that is consistent with Federal and State law;

"(vi) a governance plan that defines the manner in which the stakeholders shall jointly make policy and operational decisions on an ongoing basis;

"(vii) a financial or business plan that describes—

"(I) the sustainability of the plan;

"(II) the financial costs and benefits of the plan; and

"(III) the entities to which such costs and benefits will accrue;

"(viii) a description of whether the State in which the entity resides has received a grant under section 319D, alone or as a part of a consortium, and if the State has received such a grant, how the entity will coordinate the activities funded under such section 319D with the system under this section; and

"(ix) in the case of an applicant entity that is unable to demonstrate the participation of all stakeholders pursuant to paragraph (2)(C), the justification from the entity for any such nonparticipation.

"(4) USE OF FUNDS.—Amounts received under a grant under paragraph (1) shall be used to establish and implement a regional or local health information plan in accordance with this subsection.

"(5) MATCHING REQUIREMENT.—

"(A) IN GENERAL.—The Secretary may not make a grant under this subsection to an entity unless the entity agrees that, with respect to the costs to be incurred by the entity in carrying out the infrastructure program for which the grant was awarded, the entity will make available (directly or through donations

from public or private entities) non-Federal contributions toward such costs in an amount equal to not less than 50 percent of such costs ($1 for each $2 of Federal funds provided under the grant).

"(B) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions required under subparagraph (A) may be in cash or in kind, fairly evaluated, including equipment, technology, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

"(d) REPORTS.—Not later than 1 year after the date on which the first grant is awarded under this section, and annually thereafter during the grant period, an entity that receives a grant under this section shall submit to the Secretary a report on the activities carried out under the grant involved. Each such report shall include—

"(1) a description of the financial costs and benefits of the project involved and of the entities to which such costs and benefits accrue;

"(2) an analysis of the impact of the project on health care quality and safety;

"(3) a description of any reduction in duplicative or unnecessary care as a result of the project involved; and

"(4) other information as required by the Secretary.

"(e) AUTHORIZATION OF APPROPRIATIONS.—

"(1) IN GENERAL.—For the purpose of carrying out this section, there is authorized to be appropriated $139,000,000 for fiscal year 2008 and $139,000,000 for fiscal year 2009.

"(2) AVAILABILITY.—Amounts appropriated under paragraph (1) shall remain available through fiscal year 2012.

"SEC. 3009. DEMONSTRATION PROGRAM TO INTEGRATE INFORMATION TECHNOLOGY INTO CLINICAL EDUCATION.

"(a) IN GENERAL.—The Secretary may award grants to eligible entities or consortia under this section to carry out demonstration projects to develop academic curricula integrating qualified health information technology systems in the clinical education of health professionals or analyze clinical data sets to discover quality measures.

Such awards shall be made on a competitive basis and pursuant to peer review.

"(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity or consortium shall—

"(1) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

"(2) be or include—

"(A) a health professions school;

"(B) a school of nursing; or

"(C) an institution with a graduate medical education program;

"(3) provide for the collection of data regarding the effectiveness of the demonstration project to be funded under the grant in improving the safety of patients and the efficiency of health care delivery; and

"(4) provide matching funds in accordance with subsection (d).

"(c) USE OF FUNDS.—

"(1) IN GENERAL.—With respect to a grant under subsection (a), an eligible entity or consortium shall use amounts received under the grant in collaboration with 2 or more disciplines.

"(2) LIMITATION.—An eligible entity or consortium shall not award a grant under subsection (a) to purchase hardware, software, or services.

"(d) MATCHING FUNDS.—

"(1) IN GENERAL.—The Secretary may award a grant to an entity under or consortium this section only if the entity of consortium agrees to make available non-Federal contributions toward the costs of the program to be funded under the grant in an amount that is not less than $1 for each $2 of Federal funds provided under the grant.

"(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions under paragraph (1) may be in cash or in kind, fairly evaluated, including equipment or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such contributions.

"(e) EVALUATION.—The Secretary shall take such action as may be necessary to evaluate the projects funded under this section and publish, make available, and disseminate the results of such evaluations on as wide a basis as is practicable.

"(f) REPORTS.—Not later than 1 year after the date of enactment of this title, and annually thereafter, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate, and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives a report that—

"(1) describes the specific projects established under this section; and

"(2) contains recommendations for Congress based on the evaluation conducted under subsection (e).

"(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $2,000,000 for each of fiscal years 2008 and 2009.

"(h) SUNSET.—This provisions of this section shall not apply after September 30, 2012.".

Subpart C—Improving the Quality of Health Care

SEC. 311. CONSENSUS PROCESS FOR THE ADOPTION OF QUALITY MEASURES FOR USE IN THE NATIONWIDE INTEROPERABLE HEALTH INFORMATION TECHNOLOGY INFRASTRUCTURE.

Title XXX of the Public Health Service Act, as amended by section 305, is further amended by adding at the end the following:

"SEC. 3010. FOSTERING DEVELOPMENT AND USE OF HEALTH CARE QUALITY MEASURES.

"(a) IN GENERAL.—The Secretary shall provide for the development and use of health care quality measures (referred to in this title as 'quality measures') for the purpose of measuring the quality and efficiency of health care that patients receive.

"(b) DESIGNATION OF, AND ARRANGEMENT WITH, ORGANIZATION.—

"(1) IN GENERAL.—Not later than 90 days after the date of enactment of this title, the Secretary shall designate, and have in effect an arrangement with, a single organization that meets the requirements of subsection (c) under which such organization shall promote the development of quality measures and provide the Secretary with advice and recommendations on the key elements and priorities of a national system for healthcare performance measurement.

"(2) RESPONSIBILITIES.—The responsibilities to be performed by the organization designated under paragraph (1) (in this title referred to as the 'designated organization') shall include—

"(A) establishing and managing an integrated national strategy and process for setting

priorities and goals in establishing quality measures;

"(B) coordinating and harmonizing the development and testing of such measures;

"(C) establishing standards for the development and testing of such measures;

"(D) endorsing national consensus quality measures;

"(E) recommending, in collaboration with multi-stakeholder groups, quality measures to the Secretary for adoption and use;

"(F) promoting the development and use of electronic health records that contain the functionality for automated collection, aggregation, and transmission of performance measurement information; and

"(G) providing recommendations and advice to the Partnership regarding the integration of quality measures into the certification process outlined under section 3003 and the Community regarding national policies outlined under section 3004.

"(c) REQUIREMENTS DESCRIBED.—The requirements described in this subsection are the following:

"(1) PRIVATE ENTITY.—The organization shall be a private nonprofit entity that is governed by a board of directors and an individual who is designated as president and chief executive officer.

"(2) BOARD MEMBERSHIP.—The members of the board of directors of the entity shall include representatives of—

"(A) health care providers or groups representing providers;

"(B) health plans or groups representing health plans;

"(C) patients or consumers enrolled in such plans or groups representing individuals enrolled in such plans;

"(D) health care purchasers and employers or groups representing purchasers or employers; and

"(E) organizations that develop health information technology standards and new health information technology.

"(3) OTHER MEMBERSHIP REQUIREMENTS.—The membership of the board of directors of the entity shall be representative of individuals with experience with—

"(A) urban health care issues;

"(B) safety net health care issues;

"(C) rural or frontier health care issues;

"(D) quality and safety issues;

"(E) State or local health programs;

"(F) individuals or entities skilled in the conduct and interpretation of biomedical, health services, and health economics research and with expertise in outcomes and effectiveness research and technology assessment; and

"(G) individuals or entities involved in the development and establishment of standards and certification for health information technology systems and clinical data.

"(4) OPEN AND TRANSPARENT.—With respect to matters related to the arrangement with the Secretary under subsection (a)(1), the organization shall conduct its business in an open and transparent manner, and provide the opportunity for public comment and ensure a balance among disparate stakeholders, so that no member organization unduly influences the work of the organization.

"(5) VOLUNTARY CONSENSUS STANDARDS SETTING ORGANIZATIONS.—The organization shall operate as a voluntary consensus standards setting organization as defined for purposes of section 12(d) of

the National Technology Transfer and Advancement Act of 1995 (Public Law 104–113) and Office of Management and Budget Revised Circular A-119 (published in the Federal Register on February 10, 1998).

"(6) PARTICIPATION.—If the organization requires a fee for membership, the organization shall ensure that such fee is not a substantial barrier to participation in the entity's activities related to the arrangement with the Secretary.

"(d) REQUIREMENTS FOR MEASURES.—The quality measures developed under this title shall comply with the following:

"(1) MEASURES.—The designated organization, in promoting the development of quality measures under this title, shall ensure that such measures—

"(A) are evidence-based, reliable, and valid;

"(B) include—

"(i) measures of clinical processes and outcomes, patient experience, efficiency, and equity; and

"(ii) measures to assess effectiveness, timeliness, patient self-management, patient centeredness, and safety; and

"(C) include measures of underuse and overuse.

"(2) PRIORITIES.—In carrying out its responsibilities under this section, the designated organization shall ensure that priority is given to—

"(A) measures with the greatest potential impact for improving the performance and efficiency of care;

"(B) measures that may be rapidly implemented by group health plans, health insurance issuers, physicians, hospitals, nursing homes, long-term care providers, and other providers;

"(C) measures which may inform health care decisions made by consumers and patients;

"(D) measures that apply to multiple services furnished by different providers during an episode of care;

"(E) measures that can be integrated into certification process described in section 3003; and

"(F) measures that may be integrated into the decision support function of qualified health information technology as defined by this title.

"(3) RISK ADJUSTMENT.—The designated organization, in consultation with performance measure

developers and other stakeholders, shall establish procedures to ensure that quality measures take into account differences in patient health status, patient characteristics, and geographic location, as appropriate.

"(4) MAINTENANCE.—The designated organization, in consultation with owners and developers of quality measures, shall require the owners or developers of quality measures to update and enhance such measures, including the development of more accurate and precise specifications, and retire existing outdated measures. Such updating shall occur not more often than once during each 12-month period, except in the case of emergency circumstances requiring a more immediate update to a measure.

"(e) GRANTS FOR PERFORMANCE MEASURE DEVELOPMENT.—The Secretary, acting through the Agency for Healthcare Research and Quality, may award grants, in amounts not to exceed $50,000 each, to organizations to support the development and testing of quality measures that meet the standards established by the designated organization.

"SEC. 3011. ADOPTION AND USE OF QUALITY MEASURES; REPORTING.

"(a) IN GENERAL.—For purposes of carrying out activities authorized or required by this title to ensure the use of quality measures and to foster uniformity between health care quality measures utilized by private entities, the Secretary shall—

"(1) select quality measures for adoption and use, from quality measures recommended by multi-stakeholder groups and endorsed by the designated organization; and

"(2) ensure that standards adopted under section 3005 integrate the quality measures endorsed, adopted, and utilized under this section.

"(b) RELATIONSHIP WITH PROGRAMS UNDER THE SOCIAL SECURITY ACT.—The Secretary shall ensure that the quality measures adopted under this section—

"(1) complement quality measures developed by the Secretary under programs administered by the Secretary under the Social Security Act, including programs under titles XVIII, XIX, and XXI of such Act; and

"(2) do not conflict with the needs and priorities of the programs under titles XVIII, XIX, and XXI of such Act, as set forth by the Administrator of the Centers for Medicare & Medicaid Services.

"(c) REPORTING.—The Secretary shall implement procedures, consistent with generally accepted standards, to enable the Department of Health and Human Services to accept the electronic submission of data for purposes of performance measurement, including at the provider level, using the quality measures developed, endorsed, and adopted pursuant to this title.

"(d) DISSEMINATION OF INFORMATION.—In order to make comparative performance information available to health care consumers, health professionals, public health officials, oversight organizations, researchers, and other appropriate individuals and entities, after consultation with multi-stakeholder groups, the Secretary shall promulgate regulations to provide for the dissemination, aggregation, and analysis of quality measures collected pursuant to this title.".

Subpart D—Privacy and Security

SEC. 321. PRIVACY AND SECURITY.

Title XXX of the Public Health Service Act, as amended by section 311, is further amended by adding at the end the following:

"SEC. 3013. ENSURING PRIVACY AND SECURITY.

"(a) PRIVACY PROTECTIONS APPLY TO HEALTH INFORMATION ELECTRONIC DATABASES.—An operator of a health information electronic database shall be deemed to

be a 'covered entity' for purposes of sections 1171 through 1179 of the Social Security Act and the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-2 note) (referred to in this section as the 'HIPAA privacy regulations'.

"(b) HEALTH INFORMATION ELECTRONIC DATABASE DEFINED.—In this section, the term 'operator of a health information electronic database' means an entity that—

"(1) is constituted, organized, or chartered for the primary purpose of maintaining or transmitting protected health information in a designated record set or sets;

"(2) receives valuable consideration for maintaining or transmitting protected health information in a designated record set or sets; and

"(3) is not a health plan, healthcare clearinghouse, or healthcare provider who transmits any health information in electronic form in connection with a transaction referred to in section 1173(a)(1) of the Social Security Act.

"(c) RIGHT OF INDIVIDUALS TO INSPECT THEIR MEDICAL RECORDS MAINTAINED IN ELECTRONIC FORMAT.—To the extent provided for under the HIPAA privacy regulations with respect to protected health informa-

tion, an individual shall have a right of access to inspect and obtain a copy of protected health information about the individual stored in electronic format.

"(d) RIGHTS OF INDIVIDUALS WHO ARE VICTIMS OF MEDICAL FRAUD.—To the extent provided for under the HIPAA privacy regulations and under the conditions specified in such regulations, with respect to protected health information, an individual who is a victim of medical fraud or who believes that there is an error in their protected health information stored in an electronic format shall have the right—

"(1) to have access to inspect and obtain a copy of protected health information about the individual, including the information fraudulently entered, in a designated record set; and

"(2) to have a covered entity amend protected health information or a record about the individual, including information fraudulently entered, in a designated electronic record set for as long as the protected health information is maintained in the designated electronic record set to ensure that fraudulent and inaccurate health information is not shared or re-reported.

"(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to supercede or otherwise limit the

provisions of any contract that provides for the application of privacy protections that are greater than the privacy protections provided for under the regulations promulgated under section 264 of the Health Insurance Portability and Accountability Act of 1996.".

Subpart E—Miscellaneous Provisions

SEC. 331. GAO STUDY.

Not later than 12 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the circumstances in which it is necessary and workable to require health plans (as defined in section 1171 of the Social Security Act (42 U.S.C. 1320d)), health care clearinghouses (as defined in such section 1171), and health care providers (as defined in such section 1171) who transmit health information in electronic form, to notify individuals if their individually identifiable health information (as defined in such section 1171) is wrongfully disclosed.

SEC. 332. HEALTH INFORMATION TECHNOLOGY RESOURCE CENTER.

Section 914 of the Public Health Service Act (42 U.S.C. 299b–3) is amended by adding at the end the following:

"(d) HEALTH INFORMATION TECHNOLOGY RESOURCE CENTER.—

"(1) IN GENERAL.—The Secretary, acting through the Director, shall develop a Health Information Technology Resource Center (referred to in this subsection as the 'Center') to provide technical assistance and develop best practices to support and accelerate efforts to adopt, implement, and effectively use interoperable health information technology in compliance with sections 3003 and 3010.

"(2) PURPOSES.—The purposes of the Center are to—

"(A) provide a forum for the exchange of knowledge and experience;

"(B) accelerate the transfer of lessons learned from existing public and private sector initiatives, including those currently receiving Federal financial support;

"(C) assemble, analyze, and widely disseminate evidence and experience related to the adoption, implementation, and effective use of interoperable health information technology;

"(D) provide for the establishment of regional and local health information networks to facilitate the development of interoperability across health care settings and improve the quality of health care;

"(E) provide for the development of solutions to barriers to the exchange of electronic health information; and

"(F) conduct other activities identified by the States, local, or regional health information networks, or health care stakeholders as a focus for developing and sharing best practices.

"(3) SUPPORT FOR ACTIVITIES.—To provide support for the activities of the Center, the Director shall modify the requirements, if necessary, that apply to the National Resource Center for Health Information Technology to provide the necessary infrastructure to support the duties and activities of the Center and facilitate information exchange across the public and private sectors.

"(4) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to require the duplication of Federal efforts with respect to the establishment of the Center, regardless of whether such efforts were carried out prior to or after the enactment of this subsection.

"(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated, such sums as may be necessary for each of fiscal years 2008 and 2009 to carry out this section.".

SEC. 333. FACILITATING THE PROVISION OF TELEHEALTH SERVICES ACROSS STATE LINES.

Section 330L of the Public Health Service Act (42 U.S.C. 254c–18) is amended to read as follows:

"SEC. 330L. TELEMEDICINE; INCENTIVE GRANTS REGARDING COORDINATION AMONG STATES.

"(a) FACILITATING THE PROVISION OF TELEHEALTH SERVICES ACROSS STATE LINES.—The Secretary may make grants to States that have adopted regional State reciprocity agreements for practitioner licensure, in order to expedite the provision of telehealth services across State lines.

"(b) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out subsection (a), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2008 and 2009.".

PART II—MAKING HEALTH CARE MORE ACCESSIBLE FOR ALL AMERICANS

SEC. 341. REAUTHORIZATION OF CERTAIN TELEHEALTH PROGRAMS.

(a) TELEHEALTH NETWORK AND TELEHEALTH RESOURCE CENTERS GRANT PROGRAMS.—Section 330I(s) of the Public Health Service Act (42 U.S.C. 254c-14(s)) is amended—

(1) in paragraph (1), by striking "2006" and inserting "2012"; and

(2) in paragraph (2), by striking "2006" and inserting "2012".

(b) RURAL EMERGENCY MEDICAL SERVICE TRAINING AND EQUIPMENT ASSISTANCE PROGRAM.—Section 330J(g)(1) of the Public Health Service Act (42 U.S.C. 254c–15(g)(1)) is amended by striking "2006" and inserting "2012".

(c) MENTAL HEALTH SERVICES DELIVERED VIA TELEHEALTH.—Section 330K(g) of the Public Health Service Act (42 U.S.C. 254c–16(g)) is amended by striking "2006" and inserting "2012".

SEC. 342. QUALITY IMPROVEMENT ACTIVITIES.

Section 1154(a) of the Social Security Act (42 U.S.C. 1320c–3(a)) is amended by adding at the end the following new paragraph:

"(18) The organization shall offer quality improvement assistance to providers, practitioners, Medicare Advantage organizations offering Medicare Advantage plans under part C of title XVIII, and prescription drug sponsors offering prescription drug plans under part D of such title, including the following:

"(A) Education on quality improvement initiatives, strategies, and techniques.

"(B) Instruction on how to collect, submit, aggregate, and interpret data on measures that may be used for quality improvement, public reporting, and payment.

"(C) Technical assistance for providers and practitioners in beneficiary education to facilitate patient self-management.

"(D) Guidance on redesigning clinical processes, including the adoption and effective use of health information technology, to improve the coordination, effectiveness, and safety of care.

"(E) Assistance in improving the quality of care delivered in rural and frontier areas, including efforts to prevent or address any inconsistencies or delays in the rate of adoption of health information technology and in the effective use of such technology among entities that furnish such services in rural areas.

"(F) Assistance in improving coordination of care as patients transition between providers and practitioners, including developing the capacity to securely exchange electronic health information and helping providers and practi-

tioners to effectively use secure electronic health information to improve quality.''.

SEC. 343. SENSE OF THE SENATE REGARDING PHYSICIAN PAYMENTS UNDER MEDICARE.

It is the sense of the Senate that modifications to the Medicare fee schedule for physicians' services under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) should include provisions based on the reporting of quality measures pursuant to those adopted in section 3010 of the Public Health Service Act (as added by section 305) and the overall improvement of health care quality through the use of the electronic exchange of health information pursuant to the standards adopted under section 3003 of such Act (as added by section 301.

Subtitle B—Increasing Access to Physicians and Nurses

SEC. 351. REAUTHORIZATION OF PROGRAMS AND MISCELLANEOUS AMENDMENTS.

(a) HEALTH PROFESSIONS EDUCATION PROGRAMS.—Part F of title VII of the Public Health Service Act (42 U.S.C. 295j et seq.) is amended by adding at the end the following:

"SEC. 799C. GENERAL AUTHORIZATION OF APPROPRIATIONS.

"(a) IN GENERAL.—Notwithstanding any other provision of this title, beginning with fiscal year 2008, there is authorized to be appropriated to carry out this title, such sums as may be necessary for each of fiscal years 2008 through 2012.

"(b) REFERENCES.—Any reference in this title to a provision of this title providing for an authorization of appropriation for a fiscal year beginning with fiscal year 2008, shall be deemed to be a reference to subsection (a).".

(b) NURSING WORKFORCE DEVELOPMENT PROGRAMS.—Part A of title VIII of the Public Health Service Act (42 U.S.C. 296 et seq.) is amended by adding at the end the following:

"SEC. 809. GENERAL AUTHORIZATION OF APPROPRIATIONS.

"(a) IN GENERAL.—Notwithstanding any other provision of this title, beginning with fiscal year 2008, there is authorized to be appropriated to carry out this title, such sums as may be necessary for each of fiscal years 2008 through 2012.

"(b) REFERENCES.—Any reference in this title to a provision of this title providing for an authorization of appropriation for a fiscal year beginning with fiscal year

2008, shall be deemed to be a reference to subsection (a).".

(c) DEVELOPMENT OF METRICS TO MEASURE EFFECTIVENESS.—

(1) HEALTH PROFESSIONS PROGRAMS.—Part F of title VII of the Public Health Service Act (42 U.S.C. 295j et seq.), as amended by subsection (a), is further amended by adding at the end the following:

"SEC. 799D. DEVELOPMENT OF MEASURES OF EFFECTIVENESS.

"The Secretary shall develop and publish in the Federal Register measures of effectiveness for each of the programs carried out under this title. The Secretary shall use such measures to annually submit to the Committee on Health, Education, Labor, and Pension of the Senate and the Committee on Energy and Commerce of the House of Representatives a report concerning the effectiveness of such programs.".

(2) NURSING WORKFORCE DEVELOPMENT.—Part A of title VIII of the Public Health Service Act (42 U.S.C. 296 et seq.), as amended by subsection (b), is further amended by adding at the end the following:

"SEC. 810. DEVELOPMENT OF MEASURES OF EFFECTIVENESS.

"The Secretary shall develop and publish in the Federal Register measures of effectiveness for each of the programs carried out under this title. The Secretary shall use such measures to annually submit to the Committee on Health, Education, Labor, and Pension of the Senate and the Committee on Energy and Commerce of the House of Representatives a report concerning the effectiveness of such programs.".

(d) PROVISION OF INFORMATION TO STUDENTS.—Section 726 of the Public Health Service Act (42 U.S.C. 292v) is amended by adding at the end the following:

"(c) PROVISION OF INFORMATION TO INCOMING STUDENTS.—Each school shall provide to each student, at the time the school provides such student with a letter of acceptance to attend the school, a statement of the amount of the average aggregate amount of debt incurred by graduating students during their period of attendance at the school and the national average for such debt at all schools for the previous year (as determined by the Secretary).".

(e) ENHANCED COMPETITIVENESS.—Section 738(b)(2) of the Public Health Service Act (42 U.S.C. 293b(b)(2)) is amended—

(1) by striking "that—" and all that follows through "amounts" in subparagraph (A), and inserting "that amounts";

(2) in subparagraph (A), by striking "; and" and inserting a period; and

(3) by striking subparagraph (B).

SEC. 352. NURSE WORKFORCE ENHANCEMENT.

(a) REAUTHORIZATION OF PRACTICE AND RETENTION GRANT PROGRAM.—Section 831(h) of the Public Health Service Act (42 U.S.C. 296p(h)) is amended by striking "2003 through 2007" and inserting "2008 through 2012".

(b) STATE DEMONSTRATION PROJECTS TO PROVIDE INCENTIVES FOR NURSES TO REENTER THE WORKFORCE.—Part D of title VIII of the Public Health Service Act (42 U.S.C. 296p et seq.) is amended by adding at the end the following:

"SEC. 832. STATE DEMONSTRATION PROJECTS TO PROVIDE INCENTIVES FOR NURSES TO REENTER THE WORKFORCE.

"(a) IN GENERAL.—The Secretary shall award not to exceed 15 grants to States for the conduct of demonstration projects to evaluate incentives to encourage nurses to reenter the nursing profession at positions in healthcare facilities. For purposes of projects under this

section, a nurse shall be deemed to have reentered the workforce if such nurse is licensed and had not practiced nursing for the 3-year period prior to their return to the workforce under a project under this section.

"(b) APPLICATION.—To be eligible to receive a grant under subsection (a), a State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including—

"(1) a description of the activities to be conducted under the grant, including—

"(A) how retraining will be encouraged to update skills;

"(B) how license renewal will be encouraged;

"(C) how loan repayment under programs under this title will be monitored;

"(D) how healthcare facilities with a critical shortage of nurses will be identified and the shortage will be alleviated by the program;

"(E) how the performance of reentry nurses will be monitored and evaluated; and

"(F) how part-time positions will be created to utilize nurses reentering the profession;

"(2) an assurance that the State will provide matching funds in accordance with subsection (c);

"(3) an assurance that the State will conduct an evaluation in accordance with subsection (d); and

"(4) any other assurances required by the Secretary.

"(c) MATCHING REQUIREMENT.—The Secretary may not make grants to a State under this section unless the State involved agrees, with respect to the costs of carrying out the program under the grant, to make available non-Federal contributions (in cash or in kind) toward such costs in an amount equal to not less than $1 for each $1 of Federal funds provided under the grant.

"(d) EVALUATIONS.—A State that receives a grant under this section shall reserve 5 percent of the amount received under this grant to carry out activities to evaluate the project carried out under the grant. A State shall report to the Secretary the results of such evaluation, including the number of nurses reentering the profession in the State in years prior to the project and the number reentering such profession after the initiation of the project, and the number of such reentering nurses that serve in areas deemed underserved.

"(e) AMOUNT AND LENGTH OF GRANTS.—A grant under this section shall not exceed $2,000,000 for each

fiscal year for up to 5 years. Grants may be extended for an additional 5-year period.

"(f) DEFINITIONS.—In this section:

"(1) HEALTHCARE FACILITY.—The term 'healthcare facility' means those facilities that regularly dispense healthcare, including hospitals, public health departments, nursing homes, community health centers, rural health clinics, and Indian health service centers.

"(2) NURSE.—The term 'nurse' includes Registered Nurses.

"(3) POSITION.—The term 'position' means a full-time or part-time position that includes teaching or delivery of health care to patients.

"(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this section.".

SEC. 353. VISAS FOR REGISTERED NURSES.

Paragraph (4) of section 212(m) of the Immigration and Nationality Act (8 U.S.C. 1182(m)) is amended in the matter preceding subparagraph (A) by striking "500" and inserting "600".

SEC. 354. MEDPAC STUDY AND REPORT ON THE IMPACT OF PAYMENT CAPS FOR IME AND GME.

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study—

(1) to analyze the impact that the limitation on the number of residents in allopathic and osteopathic medicine under subsections (d)(5)(B)(v) and (h)(4)(F) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) has had with respect to—

(A) the national supply of general practitioners and specialty healthcare providers;

(B) the development of new teaching hospitals and medical schools;

(C) the ability to support residents in institutions (such as children's hospitals and advanced practice nurse training facilities) that are not eligible for payments for indirect medical education costs and direct graduate medical education costs under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.);

(D) the recruitment and retention of healthcare providers in areas designated as health professional shortage areas (as defined in section 332(a)(1) of the Public Health Service Act) or in areas designated as medically un-

derserved areas, with particular focus on States that do not have a medical school located in the State; and

(E) the practice of sharing or purchasing residency positions among institutions; and

(2) to analyze the payment system for indirect medical education costs and direct graduate medical education costs under the Medicare program under such title with respect to—

(A) the accuracy of payments for indirect graduate medical education costs under such system compared with the actual costs incurred by teaching hospitals in providing indirect medical education;

(B) the range and variance in reimbursable direct graduate medical education costs and the cause of such range and variance; and

(C) the commitment of healthcare payers, other than the Medicare program under such title, to reimburse teaching hospitals and other healthcare facilities with qualified medical education components at increased rates to offset graduate medical education costs that are incurred in such settings and are not paid under such program.

(b) REPORT.—Not later than 2 years after the date of enactment of this Act, the Medicare Payment Advisory Commission shall submit a report to the Secretary of Health and Human Services and to Congress containing the results of the study conducted under subsection (a), together with such recommendations regarding alternatives and revisions to the payment system for indirect medical education costs and direct graduate medical education costs under the Medicare program under title XVIII of the Social Security Act as the Medicare Payment Advisory Commission determines appropriate.

Subtitle C—Increasing Access to Primary Care

SEC. 361. REAUTHORIZATION OF THE COMMUNITY HEALTH CENTER PROGRAMS.

(a) IN GENERAL.—Section 330(r) of the Public Health Service Act (42 U.S.C. 254b(r)) is amended by striking paragraph (1) and inserting the following:

"(1) IN GENERAL.—For the purpose of carrying out this section, in addition to the amounts authorized to be appropriated under subsection (d), there are authorized to be appropriated—

"(A) $2,048,670 for fiscal year 2008;

"(B) $2,110,130 for fiscal year 2009;

"(C) $2,173,434 for fiscal year 2010;

"(D) $2,244,637 for fiscal year 2011; and

"(E) $2,311,976 for fiscal year 2012.".

(b) MEDICAL RESIDENCY TRAINING PROGRAMS.—Section 330 of the Public Health Service Act (42 U.S.C. 254b) is amended—

(1) by redesignating subsections (k) through (r) as subsections (l) through (s), respectively; and

(2) by inserting after subsection (j), the following:

"(k) GRANTS TO EXPAND MEDICAL RESIDENCY TRAINING PROGRAMS AT COMMUNITY HEALTH CENTERS.—

"(1) PROGRAM AUTHORIZED.—The Secretary may make grants to community health centers—

"(A) to establish, at the centers, new or alternative-campus accredited medical residency training programs affiliated with a hospital or other health care facility; or

"(B) to fund new residency positions within existing accredited medical residency training programs at the centers and their affiliated partners.

"(2) USE OF FUNDS.—Amounts awarded under a grant under this subsection shall be used to cover the costs of establishing or expanding a medical resi-

dency training program described in paragraph (1), including costs associated with—

"(A) curriculum development;

"(B) equipment acquisition;

"(C) recruitment, training, and retention of residents and faculty; and

"(D) residency stipends.

"(3) APPLICATIONS.—A community health center seeking a grant under this subsection shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

"(4) PREFERENCE.—In selecting recipients for a grant under this subsection, the Secretary shall give preference to funding medical residency training programs focusing on primary health care.

"(5) DEFINITION.—In this subsection, the term 'accredited', as applied to a new or alternative-campus medical residency training program, means a program that is accredited by a recognized body or bodies approved for such purpose by the Accreditation Council for Graduate Medical Education, except that a new medical residency training program that, by reason of an insufficient period of operation, is not eligible for accreditation on or before the date of

submission of an application under paragraph (3) shall be deemed accredited if the Accreditation Council for Graduate Medical Education finds, after consultation with the appropriate accreditation body or bodies, that there is reasonable assurance that the program will meet the accreditation standards of such body or bodies prior to the date of graduation of the first entering class in that program.".

SEC. 362. REAUTHORIZATION OF LOAN REPAYMENT PROGRAMS OF THE NATIONAL HEALTH SERVICE CORPS.

(a) IN GENERAL.—Section 338H(a) of the Public Health Service Act (42 U.S.C. 254q(a)) is amended to read as follows:

"(a) AUTHORIZATION OF APPROPRIATIONS.—For the purposes of carrying out this subpart, there are authorized to be appropriated $129,271,790 for fiscal year 2008, $133,150,393 for fiscal year 2009, $137,145,355 for fiscal year 2010, $141,260,166 for fiscal year 2011, and $145,498,421 for fiscal year 2012. Amounts appropriated under this subsection shall not be used to carry out section 338A.".

(b) STATE LOAN REPAYMENT PROGRAM.—Section 338I(i)(1) of the Public Health Service Act (42 U.S.C. 254q-1(i)(1)) is amended by striking "$12,000,000" and

all that follows through the end and inserting "$15,000,000 for each of fiscal years 2008 through 2012.".

SEC. 363. CLARIFICATION OF AUTHORITY FOR CONVENIENT CARE CLINICS TO PARTICIPATE IN MEDICAID AND SCHIP.

(a) MEDICAID.—

(1) STATE PLAN AMENDMENT.—Section 1902(a)(23)(A) of the Social Security Act (42 U.S.C. 1396a(a)(23)(A)) is amended—

(A) by inserting ", and a convenient care clinic, as defined in section 1905(y)" after "prepayment basis"; and

(B) by inserting "(other than with respect to the ability of an individual to obtain medical assistance from a convenient care clinic (as so defined))" after "Guam".

(2) DEFINITION.—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended by adding at the end the following:

"(y) For purposes of this title, the term 'convenient care clinic' means a health care facility located in a retail outlet that provides affordable and accessible, non-emergency health care (as defined by the Secretary) to consumers that is open 7 days a week, for extended hours

(as so defined) and is primarily staffed by advanced practice nurses (including nurse practitioners), as well as by physician assistants or physicians, who have advanced education in providing quality health care for common episodic ailments (as so defined).".

(b) SCHIP.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended—

(1) by redesignating subparagraphs (B) through (D) as subparagraphs (C) through (E), respectively; and

(2) by inserting after subparagraph (A), the following:

"(B) Section 1902(a)(23)(A) (but only with respect to the ability of an individual to obtain assistance from a convenient care clinic, as defined in section 1905(y)).".

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by this section take effect on October 1, 2007.

(2) DELAY IF STATE LEGISLATION REQUIRED.—In the case of a State plan under title XIX or XXI of the Social Security Act or a waiver of such plan under section 1115 of such Act which the Secretary of Health and Human Services deter-

mines requires State legislation (other than legislation appropriating funds) in order for the plan or waiver to meet the additional requirements imposed by the amendments made by this section, the State plan or waiver shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

Subtitle D—Rural Health Care

SEC. 371. REATHORIZATION OF RURAL HEALTH CARE PROGRAMS.

Section 330A(j) of the Public Health Service Act (42 U.S.C. 254c(j)) is amended by striking "$40,000,000" and all that follows and inserting "$45,000,000 for each of fiscal years 2008 through 2010.".

Subtitle E—Long Term Care

SEC. 381. SENSE OF THE SENATE.

It is the Sense of the Senate that all Americans should establish an advance directive.

SEC. 382. LIVING WILLS.

The Secretary of Health and Human Service shall provide for the development of an Internet website (at www.livingwill.gov) to provide all Americans with access to information on advance directives and a website on which to store and access such directives.

SEC. 383. INCREASING SENIOR CHOICE AND ACCESS TO COMMUNITY-BASED LONG TERM CARE.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following:

"SEC. 399R. INCREASING SENIOR CHOICE AND ACCESS TO COMMUNITY-BASED LONG TERM CARE.

"(a) IN GENERAL.—The Secretary may award one-time grants to eligible entities, as defined by the Secretary, for the conduct of demonstration projects to plan and develop the entity's transitions from institutional settings of skilled nursing care to residential or community-based settings of integrated skilled nursing care, which shall include—

"(1) the provision of housing units and staff meeting all Federal and State qualifications and licensure requirements, as applicable to the level of care to be provided;

"(2) eligibility and qualification assistance for reimbursement under applicable State Medicaid programs;

"(3) the provision of a residential or home environment which encourages independent living, privacy, and community engagement;

"(4) encouraging a sense of community by having a number of low-occupancy housing units arranged with similarly structured housing units specializing in long term care;

"(5) an emphasis on building relationships between care providers and clients by encouraging teams to remain with a set of patients throughout their stay;

"(6) the direct involvement by the clients in developing activities and structuring care needs; and

"(7) the formation of an integrated, self-managed clinical and personal care team, including healthcare providers, specialists and appropriate personnel, available to the community as needed.

"(b) APPLICATION.—An eligible entity desiring a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may reasonably require.

"(c) REPORT.—Not later than 3 years after the date on which the first grant is awarded under this section, the Secretary shall submit to the appropriate committees of Congress a report concerning the efficacy of the model carried out under this section in improving quality of life indicators, employee satisfaction, and clinical outcomes.

"(d) PRIORITY.—In making grants under this section, the Secretary shall give priority to entities providing services to a medically underserved area.

"(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of awarding grants under this section, there is authorized to be appropriated $5,000,000 for each of fiscal years 2008 through 2013.".

Subtitle F—Fair and Reliable Medical Justice

SEC. 391. SHORT TITLE.

This subtitle may be cited as the "Fair and Reliable Medical Justice Act".

SEC. 392. PURPOSES.

The purposes of this subtitle are—

(1) to restore fairness and reliability to the medical justice system by fostering alternatives to current medical tort litigation that promote early disclosure of health care errors and provide prompt, fair, and reasonable compensation to patients who are injured by health care errors;

(2) to promote patient safety through disclosure of health care errors; and

(3) to support and assist States in developing such alternatives.

SEC. 393. STATE DEMONSTRATION PROGRAMS TO EVALUATE ALTERNATIVES TO CURRENT MEDICAL TORT LITIGATION.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following:

"SEC. 399R. STATE DEMONSTRATION PROGRAMS TO EVALUATE ALTERNATIVES TO CURRENT MEDICAL TORT LITIGATION.

"(a) IN GENERAL.—The Secretary is authorized to award demonstration grants to States for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care

organizations. In awarding such grants, the Secretary shall ensure the diversity of the alternatives so funded.

"(b) DURATION.—The Secretary may award up to 10 grants under subsection (a) and each grant awarded under such subsection may not exceed a period of 5 years.

"(c) CONDITIONS FOR DEMONSTRATION GRANTS.—

"(1) REQUIREMENTS.—Each State desiring a grant under subsection (a) shall—

"(A) develop an alternative to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations; and

"(B) promote a reduction of health care errors by allowing for patient safety data related to disputes resolved under subparagraph (A) to be collected and analyzed by organizations that engage in efforts to improve patient safety and the quality of health care.

"(2) ALTERNATIVE TO CURRENT TORT LITIGATION.—Each State desiring a grant under subsection (a) shall demonstrate how the proposed alternative described in paragraph (1)(A)—

"(A) makes the medical liability system more reliable through prompt and fair resolution of disputes;

"(B) encourages the disclosure of health care errors;

"(C) enhances patient safety by detecting, analyzing, and reducing medical errors and adverse events;

"(D) maintains access to liability insurance; and

"(E) provides patients the opportunity to opt out of or voluntarily withdraw from participating in the alternative.

"(3) SOURCES OF COMPENSATION.—Each State desiring a grant under subsection (a) shall identify the sources from and methods by which compensation would be paid for claims resolved under the proposed alternative to current tort litigation, which may include public or private funding sources, or a combination of such sources. Funding methods shall to the extent practicable provide financial incentives for activities that improve patient safety.

"(4) SCOPE.—

"(A) IN GENERAL.—Each State desiring a grant under subsection (a) may establish a scope of jurisdiction (such as a designated geographic region, a designated area of health care practice, or a designated group of health care

providers or health care organizations) for the proposed alternative to current tort litigation that is sufficient to evaluate the effects of the alternative.

"(B) NOTIFICATION OF PATIENTS.—A State proposing a scope of jurisdiction under subparagraph (A) shall demonstrate how patients would be notified that they are receiving health care services that fall within such scope, and that they may opt out of or voluntarily withdraw from participating in the alternative.

"(5) PREFERENCE IN AWARDING DEMONSTRATION GRANTS.—In awarding grants under subsection (a), the Secretary shall give preference to States—

"(A) that have developed the proposed alternative through substantive consultation with relevant stakeholders, including patient advocates, health care providers and health care organizations, attorneys with expertise in representing patients and health care providers, medical malpractice insurers, and patient safety experts;

"(B) that make proposals that are likely to enhance patient safety by detecting, analyzing,

and reducing medical errors and adverse events; and

"(C) in which State law at the time of the application would not prohibit the adoption of an alternative to current tort litigation.

"(d) APPLICATION.—

"(1) IN GENERAL.—Each State desiring a grant under subsection (a) shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

"(2) REVIEW PANEL.—

"(A) IN GENERAL.—In reviewing applications under paragraph (1), the Secretary shall consult with a review panel composed of relevant experts appointed by the Comptroller General.

"(B) COMPOSITION.—

"(i) NOMINATIONS.—The Comptroller General shall solicit nominations from the public for individuals to serve on the review panel.

"(ii) APPOINTMENT.—The Comptroller General shall appoint, at least 14 but not more than 19, highly qualified and

knowledgeable individuals to serve on the review panel and shall ensure that the following entities receive fair representation on such panel:

"(I) Patient advocates.

"(II) Health care providers and health care organizations.

"(III) Attorneys with expertise in representing patients and health care providers.

"(IV) Medical malpractice insurers.

"(V) State officials.

"(VI) Patient safety experts.

"(C) CHAIRPERSON.—The Comptroller General, or an individual within the Government Accountability Office designated by the Comptroller General, shall be the chairperson of the review panel.

"(D) AVAILABILITY OF INFORMATION.—The Comptroller General shall make available to the review panel such information, personnel, and administrative services and assistance as the review panel may reasonably require to carry out its duties.

"(E) INFORMATION FROM AGENCIES.—The review panel may request directly from any department or agency of the United States any information that such panel considers necessary to carry out its duties. To the extent consistent with applicable laws and regulations, the head of such department or agency shall furnish the requested information to the review panel.

"(e) REPORTS.—

"(1) BY STATE.—Each State receiving a grant under subsection (a) shall submit to the Secretary an annual report evaluating the effectiveness of activities funded with grants awarded under such subsection.

"(2) BY SECRETARY.—The Secretary shall submit to Congress an annual compendium of the reports submitted under paragraph (1).

"(f) TECHNICAL ASSISTANCE.—

"(1) IN GENERAL.—The Secretary shall provide technical assistance to the States applying for or awarded grants under subsection (a).

"(2) REQUIREMENTS.—Technical assistance under paragraph (1) shall include—

"(A) guidance on non-economic damages, including the consideration of individual facts

and circumstances in determining appropriate payment, guidance on identifying avoidable injuries, and guidance on disclosure to patients of health care errors and adverse events; and

"(B) the development, in consultation with States, of common definitions, formats, and data collection infrastructure for States receiving grants under this section to use in reporting to facilitate aggregation and analysis of data both within and between States.

"(3) USE OF COMMON DEFINITIONS, FORMATS, AND DATA COLLECTION INFRASTRUCTURE.—States not receiving grants under this section may also use the common definitions, formats, and data collection infrastructure developed under paragraph (2)(B).

"(g) EVALUATION.—

"(1) IN GENERAL.—The Secretary, in consultation with the review panel established under subsection (d)(2), shall enter into a contract with an appropriate research organization to conduct an overall evaluation of the effectiveness of grants awarded under subsection (a) and to annually prepare and submit a report to Congress. Such an evaluation shall begin not later than 18 months following the

date of implementation of the first program funded by a grant under subsection (a).

"(2) CONTENTS.—The evaluation under paragraph (1) shall include—

"(A) an analysis of the effects of the grants awarded under subsection (a) on the measures described in paragraph (3);

"(B) a comparison between and among the alternatives approved under subsection (a) of the measures described in paragraph (3); and

"(C) a comparison between and among States receiving grants approved under subsection (a) and similar States not receiving such grants of the measures described in paragraph (3).

"(3) MEASURES.—The evaluations under paragraph (2) shall analyze and make comparisons on the basis of—

"(A) the nature and number of disputes over injuries allegedly caused by health care providers or health care organizations;

"(B) the nature and number of claims in which tort litigation was pursued despite the existence of an alternative under subsection (a);

"(C) the disposition of disputes and claims described in clauses (i) and (ii), including the length of time and estimated costs to all parties;

"(D) the medical liability environment;

"(E) health care quality;

"(F) patient safety in terms of detecting, analyzing, and reducing medical errors and adverse events; and

"(G) patient and health care provider and organization satisfaction with the alternative under subsection (a) and with the medical liability environment.

"(4) FUNDING.—The Secretary shall reserve 5 percent of the amount appropriated in each fiscal year under subsection (j) to carry out this subsection.

"(h) OPTION TO PROVIDE FOR INITIAL PLANNING GRANTS.—Of the funds appropriated pursuant to subsection (j), the Secretary may use a portion not to exceed $500,000 per State to provide planning grants to such States for the development of demonstration project applications meeting the criteria described in subsection (c). In selecting States to receive such planning grants, the Secretary shall give preference to those States in which

State law at the time of the application would not prohibit the adoption of an alternative to current tort litigation.

"(i) DEFINITIONS.—In this section:

"(1) HEALTH CARE SERVICES.—The term 'health care services' means any services provided by a health care provider, or by any individual working under the supervision of a health care provider, that relate to—

"(A) the diagnosis, prevention, or treatment of any human disease or impairment; or

"(B) the assessment of the health of human beings.

"(2) HEALTH CARE ORGANIZATION.—The term 'health care organization' means any individual or entity which is obligated to provide, pay for, or administer health benefits under any health plan.

"(3) HEALTH CARE PROVIDER.—The term 'health care provider' means any individual or entity—

"(A) licensed, registered, or certified under Federal or State laws or regulations to provide health care services; or

"(B) required to be so licensed, registered, or certified but that is exempted by other statute or regulation.

"(4) NET ECONOMIC LOSS.—The term 'net economic loss' means—

"(A) reasonable expenses incurred for products, services, and accommodations needed for health care, training, and other remedial treatment and care of an injured individual;

"(B) reasonable and appropriate expenses for rehabilitation treatment and occupational training;

"(C) 100 percent of the loss of income from work that an injured individual would have performed if not injured, reduced by any income from substitute work actually performed; and

"(D) reasonable expenses incurred in obtaining ordinary and necessary services to replace services an injured individual would have performed for the benefit of the individual or the family of such individual if the individual had not been injured.

"(5) NON-ECONOMIC DAMAGES.—The term 'non-economic damages' means losses for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companion-

ship, loss of consortium (other than loss of domestic service), injury to reputation, and all other non-pecuniary losses of any kind or nature, to the extent permitted under State law.

"(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary. Amounts appropriated pursuant to this subsection shall remain available until expended.".

○